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FULL REPORT

ALLIANCE for HEALTH EQUITY

Hospitals and Communities Improving Health Across Chicago and Cook County

COMMUNITY HEALTH NEEDS ASSESSMENT

FOR CHICAGO AND SUBURBAN COOK COUNTY

www.allhealthequity.org

ILLINOIS PUBLIC HEALTH INSTITUTE

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EXECUTIVE SUMMARY

The Alliance for Health Equity (AHE) is a partnership of hospitals, health departments, community-based organizations, and regional stakeholders that collaboratively advance health equity and wellness across Chicago and Suburban Cook County. The 2025 Community Health Needs Assessment (CHNA), the fourth CHNA completed by the Alliance, reflects a comprehensive, community-engaged effort to identify top health needs and guide strategies to improve health outcomes. Led by the Illinois Public Health Institute (IPHI) and grounded in the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 and Association for Community Health Improvement (ACHI) frameworks, this process engaged diverse partners and community members to ensure that the assessment is equity-driven, data-informed, and action-oriented.

The Alliance centers health equity in all aspects of its work, recognizing that everyone deserves a fair and just opportunity to attain their highest level of health. In Cook County, persistent health disparities such as stark differences in life expectancy, infant mortality, and chronic disease are rooted in systemic inequities driven by racism, discrimination, and disinvestment. These inequities are unjust, avoidable, and harmful to the health and prosperity of the entire region, and addressing them requires a deep focus on the social and economic conditions that shape health, including housing, education, income, and access to care. Guided by principles of racial justice and intersectionality, the Alliance is committed to identifying and addressing the root causes of health inequities through cross-sector collaboration, community partnership, and structural change.

METHODS

The 2025 CHNA used a mixed-methods approach to gather both primary and secondary data. Primary data collection included surveys and focus groups with community members as well as meetings with hospital community advisory councils. Data collection focused on gathering input from those underrepresented in traditional assessments and was conducted in partnership with community-based organizations. Secondary data was compiled from a wide range of public health, demographic, and social determinants datasets. Data collection and analysis were guided by the MAPP 2.0 framework, ACHI framework, and County Health Rankings and Roadmaps Model to ensure a community-engaged, equity-focused process.

COMMUNITY DESCRIPTION

Cook County, Illinois is the second most populous county in the United States and includes Chicago, the third largest U.S. city. As of 2023, Cook County is home to more than 5 million residents, with an estimated 2.7 million residents across 77 Chicago community areas and 2.4 million residents in 130 suburban Cook County municipalities. These population estimates represent a 3.6% decline since 2020.

The County is racially and ethnically diverse, with more than half of residents identifying as members of historically marginalized groups. It is also home to large immigrant populations, significant numbers of individuals with limited English proficiency, and communities disproportionately affected by structural racism, economic disinvestment, and health inequities. In 2023, 21% of the population was younger than age 18 and 17% was older than age 65. Approximately 11% of county residents reported living with a disability, and 31% of older adults live alone. Cook County has high geographic concentrations of single-parent households, low life expectancy, and self-reported poor mental and physical health, particularly in South and West Side neighborhoods and southern suburbs.

Priority populations for this assessment included individuals experiencing homelessness, immigrants and refugees, people living with disabilities or behavioral health conditions, LGBTQIA+ communities, youth, justice-involved individuals, and veterans. These populations face distinct barriers to health and well-being and require tailored, equity-focused strategies to address their needs. This CHNA highlights the importance of understanding and addressing inequities to improve health outcomes across the region.

COMMUNITY-IDENTIFIED HEALTH PRIORITIES

Community input is foundational to the AHE assessment process. We recognize that the most timely and relevant insights into community health come directly from those with lived experience and on-the-ground expertise. Focus groups and surveys were designed to center the voices of residents and community-based organizations, particularly those historically underrepresented in traditional assessments. Their input not only shaped the identification of priority health issues and needs but also informs the strategies we pursue to advance health and racial equity across Cook County.

Focus group participants across Cook County highlighted several interrelated health priorities shaped by social, economic, and structural inequities. The most commonly identified issues included poor access to affordable and timely healthcare, rising rates of chronic conditions like diabetes and hypertension, and a widespread mental health crisis compounded by stigma, lack of services, and trauma. Participants also raised concerns about substance use disorders, especially among youth and individuals experiencing homelessness, and emphasized the need for culturally responsive care. Additional priorities included women's health and maternal care, health inequities among children and adolescents, and the critical impact of economic instability, food and housing insecurity, and community violence on health. Across all groups, participants called for expanded community-based services, youth programming, mental health supports, and systemic solutions that address the root causes of health inequities.

Community input from focus groups mirrored feedback from survey respondents. Based on responses from nearly 1,800 community members across Cook County, the top health issues and needs identified by survey participants reflect significant concern for mental health, chronic conditions, and the broader social determinants of health.

Survey respondents most frequently identified the following as the biggest health issues in their communities:

- Adult mental health including depression, anxiety, and PTSD (26%)
- Diabetes (22%)
- Substance use including alcohol, prescription misuse, and illicit drugs (22%)
- Obesity (19%)
- Homelessness and housing instability (18%)

When asked what their communities need to be healthy, participants most often selected:

- Activities for teens and youth (26%)
- Access to mental health services (26%)
- Housing resources including emergency shelters and housing support (24%)
- Safety and low crime (22%)
- Safe and affordable housing (20%)
- Resources for food including pantries, food banks, love kitchens, and SNAP programs (19%)

The survey responses and focus group findings show strong alignment around key health priorities in Cook County, reinforcing both the validity of the data and urgency of certain issues.

Mental health

Survey: Adult mental health was the top concern (26%) and access to mental health services was among the most commonly cited needs (26%).

Focus groups: Participants described mental healthcare challenges across all age groups, including lack of services, long wait times, stigma, and lack of culturally relevant care. In addition, residents described widespread experiences of stress, depression, anxiety, trauma, and social isolation that were often shaped by economic hardship, violence, discrimination, and lack of access to care.

Chronic conditions (Diabetes, Obesity, Hypertension)

Survey: Diabetes (22%) and obesity (19%) were among the top reported health issues.

Focus groups: Chronic conditions, particularly diabetes, hypertension, heart disease, asthma, and obesity, were consistently raised as top health concerns. Participants described these conditions as widespread in their communities and deeply connected to food access, cost of living increases, environmental conditions, and lack of preventive care.

Substance use

Survey: Substance use was identified as a major health issue by 22% of respondents.

Focus groups: Substance use was described in detail, particularly its links to untreated mental health, trauma, housing instability, youth development, and safety concerns (e.g., public use, overdose risks, and fentanyl). Participants described a lack of accessible, affordable, and timely treatment options such as residential treatment, outpatient counseling, and harm reduction services.

Housing and homelessness

Survey: Homelessness and housing instability (18%) were top health issues. Safe and affordable housing (20%) and housing resources (24%) were among the top needs.

Focus groups: Housing insecurity was described as a root cause of stress, instability, and poor health outcomes, particularly for vulnerable populations. Many participants described the rising cost of rent, long waiting lists for housing assistance programs (such as Section 8), and the lack of affordable housing options in their communities, saying these forced families to make difficult trade-offs between housing, food, healthcare, and other basic needs.

Youth needs

Survey: Activities for teens and youth were the most commonly selected health needs (26%).

Focus groups: Lack of youth programming, safe spaces, and mental health support for adolescents was a major theme. Youth substance use and school-related safety also were cited. Participants called for greater investment in programs, services, and environments that support youth development, mental health, and overall well-being.

Food access and security

Survey: Resources for food pantries, food banks, love kitchens, and SNAP programs were selected as top health needs by 19% of survey respondents. In addition, 25% of respondents indicated that they were not satisfied with the availability of fresh and healthy food in their communities.

Focus groups: Participants described significant barriers to accessing healthy food, including high prices, poor food quality, and a lack of nearby full-service grocery stores. Community members also discussed the prevalence of processed food and the absence of culturally appropriate options.

Community safety

Survey: Safety and low crime were selected as a top community need by 22% of respondents. More than 20% of respondents indicated that their communities were not safe places to live.

Focus groups: Safety was a cross-cutting concern, especially gun violence, unsafe public spaces, and infrastructure-related hazards. Participants referenced youth and noted the lack of safe spaces for young people to gather, leading to increased exposure to unsafe environments and risky behaviors. Concerns also emerged around over-policing and criminalization of youth, especially Black and Brown adolescents, which many felt contributed to cycles of trauma and mistrust.

These findings underscore the interconnectedness of physical, mental, and social health, and point to the need for integrated, equity-focused strategies to address root causes of poor health outcomes in Cook County communities.

Conclusion

The 2025 CHNA underscores the urgent and interconnected challenges facing communities across Chicago and Suburban Cook County. Through robust community engagement and cross-sector collaboration, the Alliance has identified shared priorities including mental health, chronic conditions, substance use, housing instability, youth supports, food access and insecurity, community safety, and socioeconomic influencers of health as key areas for action. These findings will guide collective efforts to advance health equity, inform strategic investments, and support community-driven solutions that improve health and well-being for all residents.

INTRODUCTION

The Alliance for Health Equity (AHE) is a partnership of hospitals, health departments, community-based organizations, and other regional stakeholders that are working collaboratively to improve health equity, wellness, and quality of life across Chicago and Suburban Cook County communities.

Health assessment is an important component of the Alliance's work and allows partners to collaboratively identify top community health needs and to design community-driven strategies to address those needs. This is the fourth Community Health Needs Assessment (CHNA) completed by AHE; the 2025 CHNA was completed between June 2023 and December 2024.

COLLABORATIVE STRUCTURE

Alliance for Health Equity is comprised of a steering committee and several workgroups and committees working on implementation strategies for several community health priorities. The Illinois Public Health Institute (IPHI) serves as the backbone organization.

The steering committee is made up of hospital, health system, and health department leaders who decide the strategic direction of the Alliance for Health Equity, guide IPHI staff, oversee collective impact strategies, and ensure that all activities align with the AHE purpose, vision, and values. All member health systems and independent hospitals have representation on the steering committee, as does the Chicago Department of Public Health (CDPH) and the Cook County Department of Public Health (CCDPH). A list of steering committee members is available in the Appendix. The steering committee meets regularly and makes decisions by consensus and through the designation of ad-hoc committees as needed.

The Alliance for Health Equity has implementation strategy committees and workgroups focused on mental health and substance use disorders, medical respite and housing, social and structural determinants of health, and food access and food security.

The CHNA Committee provides oversight and assistance with the development of assessments and implementation plans.

COMMUNITY HEALTH NEEDS ASSESSMENT APPROACH AND METHODS

IPHI worked with the Alliance's CHNA Committee to design and facilitate a collaborative, community-engaged assessment. Primary and secondary data from a diverse range of sources allowed for robust data analysis and the identification of community health needs in Chicago and Suburban Cook County. The Alliance for Health Equity collaborative CHNA process is adapted from the MAPP 2.0 (Mobilizing for Action through Planning and Partnerships 2.0) framework, a community-engaged strategic planning framework developed by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC).

The Chicago and Cook County Departments of Public Health, as well as the Illinois Department of Public Health, all use the MAPP 2.0 framework for community health assessment and planning. The MAPP 2.0 framework centers a community-engaged approach to assessment and planning, with a system and equity focus, emphasizing the importance of community engagement, partnership development, and the dynamic interplay of factors and forces within the public health system. The Alliance for Health Equity chose this inclusive, community-driven process to leverage and align with health department assessments, and actively engage community members and representatives across organizational sectors. Together these partners identified and addressed strategic priorities to advance health equity.

For our CHNA, the Alliance for Health Equity takes an intentional approach to build on our previous collaborative CHNA work (2016, 2019, 2022) with Healthy Chicago, and Suburban Cook County WePLAN.

To continue collaborative momentum to advance health equity in Chicago and Suburban Cook County, the CHNA Committee agreed upon the following goals and parameters for the 2025 CHNA process :

- review the health status of communities in chicago and suburban cook county
- refine strategies for community health improvement to support current and new implementation activities
- use a racial equity framework to identify priority populations, identify/refine priority health strategies, and direct implementation efforts
- use an asset-based perspective to update collective understanding of existing projects, programs, and resources
- review potential short- and long-term threats and opportunities related to community health improvement
- identify policy priorities and opportunities for collective action.

The Alliance for Health Equity strives to integrate a strong ethos of community engagement throughout all of our work. We prioritize the engagement of community members and community-based organizations as a critical component of assessing and addressing community health needs. We recognize that the most up-to-date data and information about health and social well-being and needs comes from community partners and community members with lived experience and on-the-ground expertise. We work to strengthen our approach to health and racial equity by incorporating community co-design and engagement in decision-making about priority health needs and strategies.

Community partners and community members are involved in the assessment and ongoing implementation process in several ways, providing input and participating in decision-making processes. Our methods of community engagement for the CHNA and implementation strategies include:

- gathering input from community residents who are underrepresented in traditional assessment and implementation planning processes;
- partnering with community-based organizations to collect community input through surveys and focus groups;
- engaging community-based organizations and community residents as members of implementation committees and workgroups;
- utilizing the expertise of implementation committee and workgroup members to design assessments, interpret data, and identify effective implementation strategies and evaluation metrics;
- working with hospital and health department community advisory groups to gather input on the chna and implementation strategies;
- working with community partners to pursue funding opportunities to support implementation; and
- partnering with local coalitions to support and align with existing community-driven efforts.

Community-based organizations engaged in the Alliance for Health Equity represent a broad range of sectors such as safety net services, housing and homeless services, food access and food justice, community safety, planning and community development, immigrant and refugee rights,

youth development, employment and workforce, community organizing, faith communities, mental health services, substance use and harm reduction services, policy and advocacy, transportation, older adult services, healthcare services, and education. All community partners work with or represent communities that are disproportionately affected by health inequities such as communities of color, immigrants, youth, older adults and caregivers, LGBTQIA+, individuals experiencing homelessness or housing instability, individuals living with mental illness or substance use disorders, individuals with disabilities, veterans, and unemployed youth and adults.

Hospitals and health systems that are members of the Alliance for Health Equity are very active in designing and implementing our collective health equity purpose. For the CHNA, all AHE hospitals and health systems:

- collaborated with IPHI, health departments, and community organizations to design and implement the CHNA process;
- participated in identifying indicators for data analysis;
- provided input to develop survey questions and focus group questions;
- identified and attend community events to collect surveys;
- identified priority populations for focus groups and host organizations;
- shared existing data or assessments that are relevant and/or contribute to data interpretation;
- engaged networks of community partners and hospital staff to collect community input and factor in that input when defining community health priorities for local service areas;
- reviewed assessment data and assist with developing findings and identifying priority strategic issues; and
- designated CHNA Committee representative(s) to provide strategic guidance to the Alliance for Health Equity and IPHI staff.

The Chicago Department of Public Health (CDPH) and Cook County Department of Public Health (CCDPH) are founding members of the Alliance for Health Equity and sit on the steering committee. A list of participating hospitals and health departments is included in the Appendix.

METHODS

The Alliance for Health Equity documents the health status of communities within Chicago and Suburban Cook County by combining robust public health data and community input with existing research, plans, and assessments. Taken together, the information highlights the systemic inequities that are negatively impacting health. In addition, the CHNA provides insight into community-based assets and resources that could be leveraged or enhanced during the implementation of health improvement strategies.

Primary data collection

For this CHNA, the Alliance for Health Equity collected primary data through three methods:

- community input surveys
- focus groups with community residents and/or service providers
- regional-focused meetings with hospital advisory boards or other cross-sector regional groups.

Community input surveys

The community input survey was designed to complement existing surveys such as the Healthy Chicago Survey, Healthy Cook County Survey, Healthy Illinois Survey, and Behavioral Risk Factor Surveillance Survey. The survey asked participants to rank priority health needs, rate their individual

health status as well as the quality of life in their communities, and identify community strengths and opportunities for improvement.

IPHI, hospitals, community-based organizations, and health departments distributed surveys to gain insight from priority populations that are most impacted by health inequities. Between February and October 2024, Alliance for Health Equity partners collected more than 1,800 community input surveys from individuals ten or older living in Chicago and Suburban Cook County. The surveys were available on paper and online in English, Spanish, Polish, and Mandarin; more than a third of the surveys were collected on paper.

IPHI and the CHNA Committee took the following steps for the community input survey:

1. IPHI drafted a survey based on the previous Alliance for Health Equity survey tools, a review of existing tested survey questions, and peer-reviewed standards for survey development.
2. CHNA Committee members provided feedback about their priority survey questions.
3. IPHI incorporated revisions from the CHNA Committee members and partner organizations with survey expertise.
4. IPHI contracted with professional translators to develop Spanish, Polish, and Mandarin versions of the survey. The translations were reviewed and copy edited by a second translator.
5. The survey tool was put into the web-based survey platform Alchemer, and PDF versions were formatted to print for in-person events.
6. The online survey was tested on Microsoft Windows and MacOS desktop platforms as well as Android and iOS mobile platforms before public release.
7. The final survey tool included 41 questions: two multi-select questions about health priorities and needs; 17 ranking questions about community well-being; five questions about flu and COVID-19; one open-ended question about the best things in the community; two questions related to zip code and community of residence; and 14 demographic questions. The survey tool is included in the Appendix.
8. Paper surveys were entered into the Alchemer platform. Survey data was analyzed with Alchemer, Microsoft Excel, and Dedoose 10.0.

Focus groups

Between January and October 2024, IPHI worked with Alliance for Health Equity partners to complete 46 focus groups with community members throughout Chicago and Suburban Cook County in partnership with Rush University Medical Center (Rush). Alliance for Health Equity partners focused on gathering input from communities that are historically marginalized and systemically excluded from assessment and decision-making processes. These communities shoulder an unequal burden of health inequities. Participants included youth and adults, and represented a diverse range of ethnic, racial, religious, and socioeconomic backgrounds.

IPHI, Rush, and the CHNA Committee took the following steps for the focus groups:

- IPHI refined the focus group questions based on previous Alliance for Health Equity focus groups, using resources from CHNA toolkits and peer-reviewed studies, and in consultation with the CHNA Committee and colleagues. The focus group guide is included in the Appendix.
- Most focus groups were 90 minutes long with an average of 10 participants. Depending on the needs of the group, some groups were shorter (60 minutes) or included more participants.
- Most focus groups were conducted in-person, but a virtual option was offered.
- All focus group participants received a gift card to recognize their participation and contributions to the CHNA process.

- A trained facilitator moderated each session and was joined by a notetaker who recorded the session while typing notes and observations on a laptop. The facilitators and notetakers applied trauma-informed facilitation practices.
- Focus group facilitators asked participants about descriptions of their communities focused on community strengths; health issues and challenges in the community; the underlying root causes of health issues; health promoters (i.e., factors that help promote health); solutions to identified health needs, (including investment opportunities); and a vision for the future.
- Recordings were stored securely on a server at IPHI and/or Rush and not shared due to the use of first names during focus groups.
- No names were included in any version of the written notes, and other potentially identifying details were redacted.
- The full-length audio recordings were reviewed, and codes/sub-codes were created.
- Themes and contrasting thoughts or opinions were highlighted.
- Dedoose 10.0 was used to organize, code, and analyze the data.

Secondary data

Epidemiologists from CCDPH and CDPH and team members at Metopio were invaluable partners in identifying, compiling, and analyzing secondary data for the CHNA. IPHI and the CHNA Committee (including CDPH, CCDPH, and Metopio) worked to refine a common set of indicators that has been used in our previous collaborative CHNAs based on an adapted version of the County Health Rankings and Roadmaps Model.

The Alliance for Health Equity made three main adaptations to the original County Health Rankings and Roadmaps model, to keep with local priorities: including behavioral health as a major category of data; applying a root cause and racial equity analysis to data where possible; and including additional child and youth data where available. The core components of the model include the following health topics:

- Social and Structural Determinants of Health
- Health Care Access and Clinical Care
- Health Behaviors
- Behavioral Health - Mental Health and Substance Use
- Maternal and Child Health
- Health Outcomes - Birth Outcomes, Morbidity, and Mortality

Chicago Health Atlas, Cook County Health Atlas, and Metopio provided secondary data for the CHNA. Data for each indicator was pulled from the respective databases and then compared across geography (zip code, service area, county, state, etc.) and various stratifications (race, age, gender, etc.) to identify trends and correlations for each topic area. Secondary data was compiled between October 2024 and January 2025 by IPHI, Health Atlases, and Metopio from a range of sources:

- Chicago Department of Public Health, Cook County Department of Public Health, and Illinois Department of Public Health
- peer-reviewed literature and white papers
- existing assessments and plans focused on key topic areas
- Healthy Chicago Survey and Healthy Cook County Survey
- local agencies including Chicago Metropolitan Agency for Planning, Chicago Department of Family and Support Services, Chicago Department of Planning and Development, homelessness continuums of care, and local police departments
- local community-based organizations including Greater Chicago Food Depository and Feeding America, Voices of Child Health in Chicago, Healthy Chicago Equity Zones,

and Building Healthier Communities Cook County
- hospitalization and emergency department rates (COMPdata) reported by the Illinois Department of Public Health
- state agencies including the Illinois Department of Healthcare and Family Services, Illinois Department of Human Services, Illinois State Board of Education, and Illinois Department of Public Health
- federal sources including the U.S. Census Bureau American Community Survey, Centers for Disease Control and Prevention PLACES project, Centers for Medicare and Medicaid Services (accessed through the Dartmouth Atlas of Health Care), Health Resources and Services Administration, and United States Department of Agriculture.

COMMUNITY DESCRIPTION

Cook County, Illinois, is comprised of 130 suburban municipalities and 77 Chicago areas. Figure 1 can be referenced when viewing maps throughout the CHNA report, and alphanumeric coordinates allow for localization of individual communities. As of 2023, the estimated population for Cook County is 5,087,072, with 2,664,452 in Chicago and 2,422,620 in Suburban Cook County. This is an estimated 3.6% decrease from the 2020 population (US Census Bureau, 2024).

The 232 **Suburban Cook municipalities** and **Chicago Community Areas** included in the CHNA are provided in Figure 2. These individual geographies can be located on the map using their reference number and alphanumeric coordinate.

Figure 1.

Chicago and Cook County Reference Map

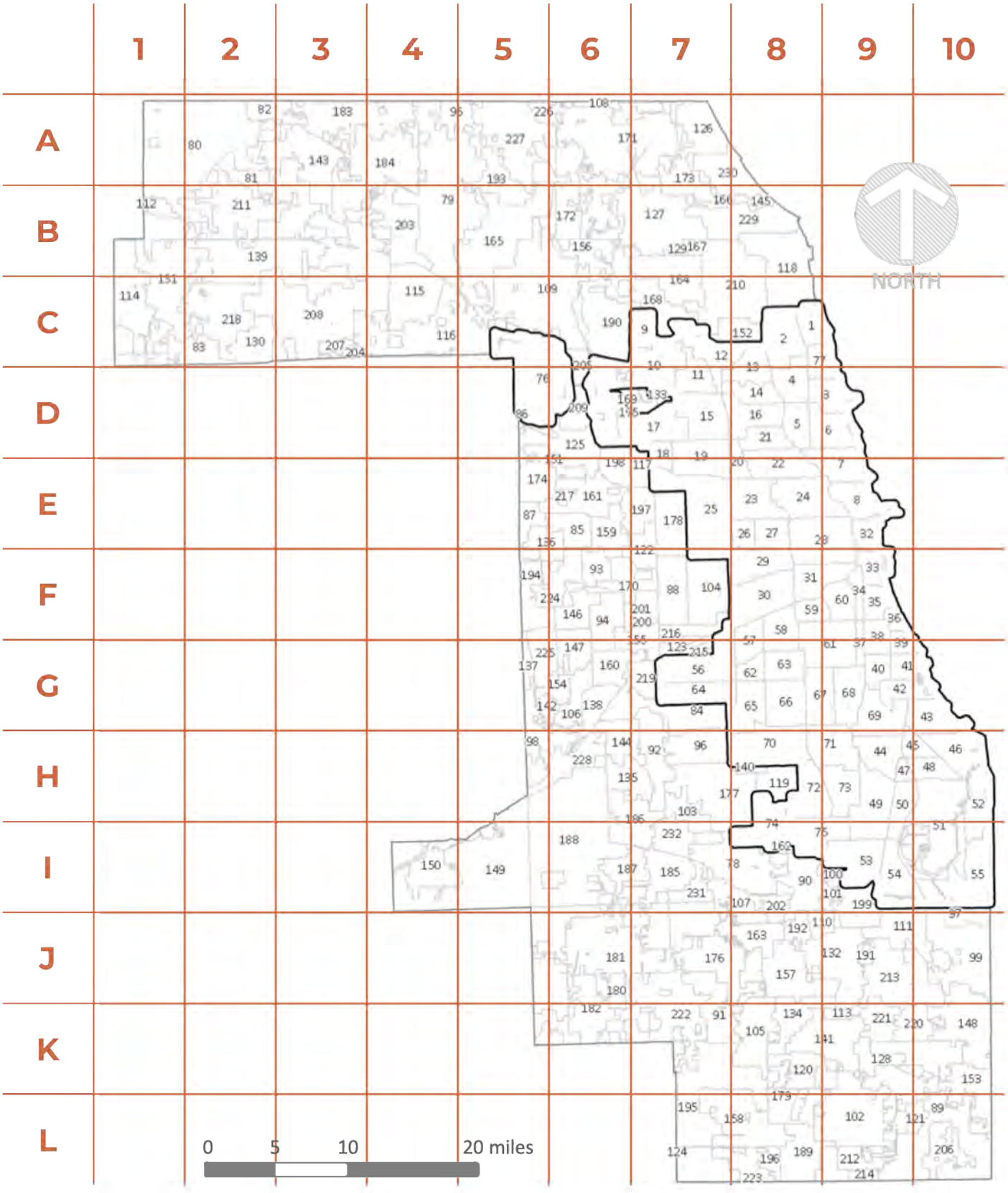

Figure 2.

List of Suburban Cook municipalities and Chicago Community Areas

CHICAGO COMMUNITY AREAS

D8 - Albany Park, 14
F8 - Archer Heights, 57
F9 - Armour Square, 34
H8 - Ashburn, 70
H9 - Auburn Gresham, 71
E7 - Austin, 25
H9 - Avalon Park, 45
D8 - Avondale, 21
D7 - Belmont Cragin, 19
H8 - Beverly, 72
F9 - Bridgeport, 60
F8 - Brighton Park, 58
H9 - Burnside, 47
H10 - Calumet Heights, 48
H9 - Chatham, 44
G8 - Chicago Lawn, 66
G7 - Clearing, 64
F9 - Douglas, 35
D7 - Dunning, 17
E8 - East Garfield Park, 27
H10 - East Side, 52
C8 - Edgewater, 77
C7 - Edison Park, 9
G9 - Englewood, 68
C7 - Forest Glen, 12
G9 - Fuller Park, 37
G8 - Gage Park, 63
G7 - Garfield Ridge, 56
F9 - Grand Boulevard, 38
G9 - Greater Grand Crossing, 69
I10 - Hegewisch, 55
E8 - Hermosa, 20
E8 - Humboldt Park, 23
G9 - Hyde Park, 41
D8 - Irving Park, 16
D7 - Jefferson Park, 11
G9 - Kenwood, 39
D9 - Lakeview, 6
E9 - Lincoln Park, 7
D8 - Lincoln Square, 4
E8 - Logan Square, 22
E9 - Loop, 32
F8 - Lower West Side, 31
F8 - McKinley Park, 59
D7 - Montclare, 18
I8 - Morgan Park, 75
I8 - Mount Greenwood, 74
E9 - Near North Side, 8
F9 - Near South Side, 33
E8 - Near West Side, 28
G9 - New City, 61
D8 - North Center, 5
F8 - North Lawndale, 29
C8 - North Park, 13
C7 - Norwood Park, 10
F9 - Oakland, 36
D5 - O'Hare, 76
D7 - Portage Park, 15
H9 - Pullman, 50
I9 - Riverdale, 54
C8 - Rogers Park, 1
H9 - Roseland, 49
H10 - South Chicago, 46
I10 - South Deering, 51
F8 - South Lawndale, 30
G10 - South Shore, 43
D9 - Uptown, 3
H9 - Washington Heights, 73
G9 - Washington Park, 40
G8 - West Elsdon, 62
G8 - West Englewood, 67
E8 - West Garfield Park, 26
G8 - West Lawn, 65
I9 - West Pullman, 53
C8 - West Ridge, 2
E8 - West Town, 24
G9 - Woodlawn, 42

COOK COUNTY UNICIPALITIES

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A2 - Uninc Barrington township, 81
A2 - Barrington village, 82
C2 - Bartlett village, 83
G7 - Bedford Park village, 84
E6 - Bellwood village, 85
D5 - Bensenville village, 86
E5 - Berkeley village, 87
F7 - Berwyn, 88
L10 - Uninc Bloom township, 89
I8 - Blue Island, 90
K7 - Uninc Bremen township, 91
H7 - Bridgeview village, 92
F6 - Broadview village, 93
F6 - Brookfield village, 94
A4 - Buffalo Grove village, 95
H7 - Burbank, 96
I10 - Burnham village, 97
H5 - Burr Ridge village, 98
J10 - Calumet City, 99
I9 - Calumet Park village, 100
I9 - Uninc Calumet township, 101
L9 - Chicago Heights, 102
H7 - Chicago Ridge village, 103
F7 - Cicero, 104
K8 - Country Club Hills, 105
G6 - Countryside, 106
I8 - Crestwood village, 107
A6 - Deerfield village, 108
C5 - Des Plaines, 109
J8 - Dixmoor village, 110
J9 - Dolton village, 111
B1 - East Dundee village, 112
K9 - East Hazel Crest village, 113
C1 - Elgin, 114
C4 - Uninc Elk Grove township, 115
C4 - Elk Grove Village, 116
E6 - Elmwood Park village, 117
B8 - Evanston, 118
H8 - Evergreen Park village, 119
K8 - Flossmoor village, 120
L9 - Ford Heights village, 121
F6 - Forest Park village, 122
G7 - Forest View village, 123
L7 - Frankfort village, 124
D6 - Franklin Park village, 125
A7 - Glencoe village, 126
B7 - Glenview village, 127
K9 - Glenwood village, 128
B7 - Golf village, 129
C2 - Hanover Park village, 130
C1 - Uninc Hanover township, 131
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D7 - Harwood Heights village, 133
K8 - Hazel Crest village, 134
H6 - Hickory Hills, 135
E5 - Hillside village, 136
G5 - Hinsdale village, 137
G6 - Hodgkins village, 138
B2 - Hoffman Estates village, 139
H8 - Hometown, 140
K8 - Homewood village, 141
G5 - Indian Head Park village, 142
A3 - Inverness village, 143
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F6 - La Grange Park village, 146
G6 - La Grange village, 147
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E6 - Uninc Leyden township, 151
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K10 - Lynwood village, 153
G6 - Uninc Lyons township, 154
F6 - Lyons village, 155
B6 - Uninc Maine township, 156
J8 - Markham, 157
L7 - Matteson village, 158
E6 - Maywood village, 159
G6 - McCook village, 160
E6 - Melrose Park village, 161
I8 - Merrionette Park village, 162
J8 - Midlothian village, 163
C7 - Morton Grove village, 164
B5 - Mount Prospect village, 165
B7 - Uninc New Trier township, 166
B7 - Uninc Niles township, 167
C7 - Niles village, 168
D6 - Norridge village, 169
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A6 - Northbrook village, 171
B6 - Uninc Northfield township, 172
A7 - Northfield village, 173
E5 - Northlake, 174
D6 - Uninc Norwood Park township, 175
J7 - Oak Forest, 176
H7 - Oak Lawn village, 177
E7 - Oak Park village, 178
L8 - Olympia Fields village, 179
J6 - Orland Hills village, 180
J6 - Orland Park village, 181
K6 – Uninc Orland township, 182
A3 – Uninc Palatine township, 183
A4 - Palatine village, 184
I7 - Palos Heights, 185
H6 - Palos Hills, 186
I6 - Palos Park village, 187
I6 - Uninc Palos township, 188
L7 - Park Forest village, 189
C6 - Park Ridge, 190
J9 - Phoenix village, 191
J8 - Posen village, 192
A5 - Prospect Heights, 193
F5 - Uninc Proviso township, 194
L7 - Uninc Rich township, 195
L8 - Richton Park village, 196
E6 - River Forest village, 197
E6 - River Grove village, 198
I9 - Riverdale village, 199
F6 - Uninc Riverside township, 200
F6 - Riverside village, 201
I8 - Robbins village, 202
B4 - Rolling Meadows, 203
C3 - Roselle village, 204
C6 - Rosemont village, 205
L10 - Sauk Village, 206
C3 - Uninc Schaumburg township, 207
C3 - Schaumburg village, 208
D6 - Schiller Park village, 209
C7 - Skokie village, 210
B2 - South Barrington village, 211
L9 - South Chicago Heights Village, 212
J9 - South Holland village, 213
L9 - Steger village, 214
G7 - Uninc Stickney township, 215
F7 - Stickney village, 216
E6 - Stone Park village, 217
C2 - Streamwood village, 218
G7 - Summit village, 219
K9 - Uninc Thornton township, 220
K9 - Thornton village, 221
K7 - Tinley Park village, 222
L8 - University Park village, 223
F5 - Westchester village, 224
G5 - Western Springs village, 225
A5 - Uninc Wheeling township, 226
A5 - Wheeling village, 227
H6 - Willow Springs village, 228
B8 - Wilmette village, 229
A7 - Winnetka village, 230
I7 - Uninc Worth township, 231
I7 - Worth village, 232

POPULATION TRENDS

Cook County, Illinois is the second most populous county in the United States, and Chicago is the third most populous U.S. city. The estimated population within Cook County has decreased slightly since 2020 (Figure 3).

Figure 3. Table of the population over time in Cook County, Illinois, 2005-2023

YEAR	TOTAL POPULATION
2005	5,206,357
2010	5,194,675
2015	5,238,216
2020	5,275,541
2023	5,087,072

Source: (US Census Bureau, 2024)

POPULATION COMPOSITION

Age and gender

In 2023, 21% of the population in Cook County was under the age of 18 and 17% was over the age of 65 (Figure 4). In Cook County, the percentage of people who identify as male or female is approximately equal (US Census Bureau, 2024). Data for the transgender population in Cook County is limited. Based on the 2018 Healthy Chicago Survey, approximately 12,000 or 0.6% of the population in Chicago identifies as transgender or gender non-conforming (Chicago Department of Public Health, 2019). The Illinois Department of Children and Family Services conducted a survey about youth in care across all sexual orientations, gender identities, and gender expressions. Based on the responses, 4% of youth identify as transgender and 4% of youth identify as nonbinary (Illinois Department of Children and Family Services Division of Diversity Equity and Inclusion et al., 2022)).

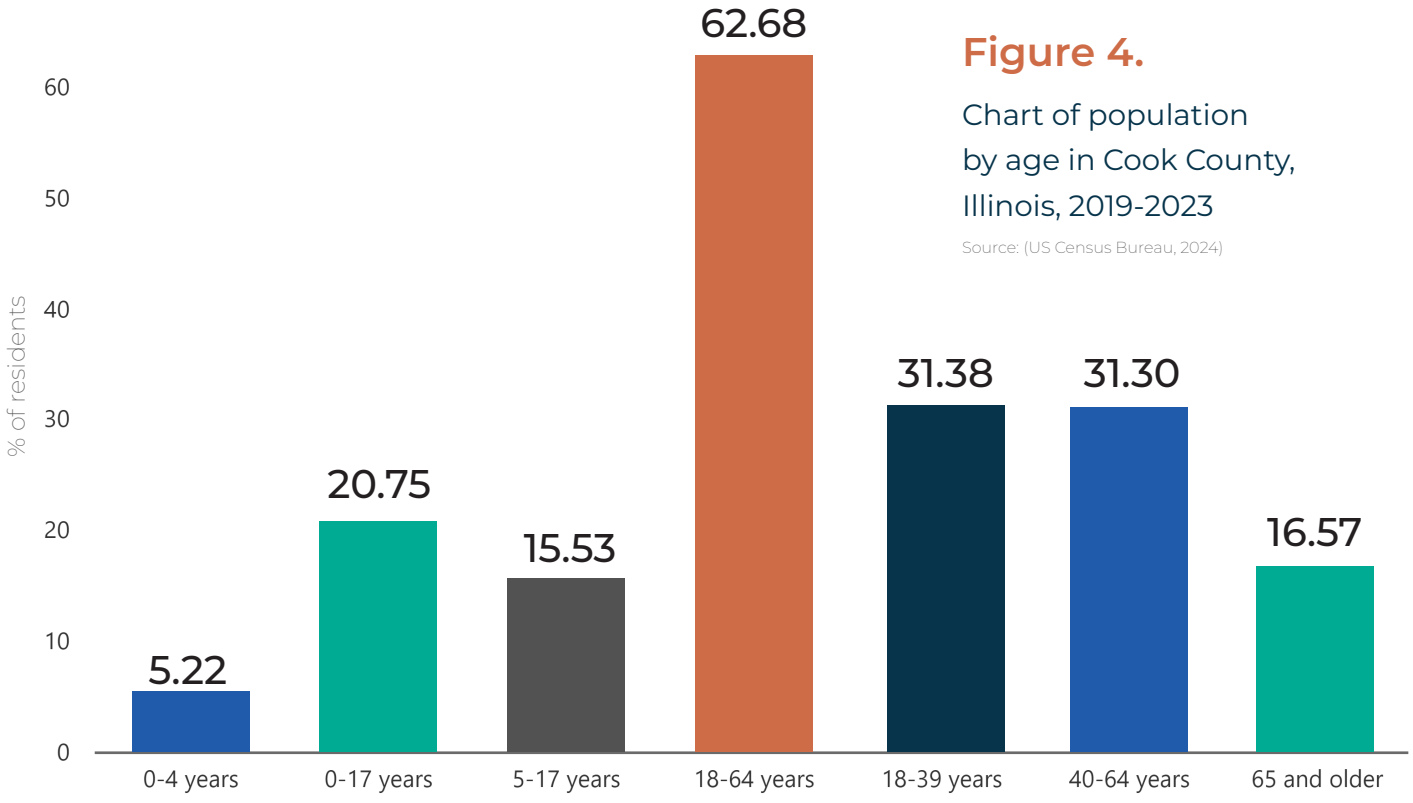


Figure 4.

Chart of population by age in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, 2024)

Race and ethnicity

More than half the population in Cook County identifies as a historically marginalized racial or ethnic group (Non-Hispanic Black, Asian, Hispanic or Latino, Native American, Pacific Islander/ Native Hawaiian, Two or more races) (Figure 5). The geographic density of Non-Hispanic Black and Hispanic or Latino residents in Cook County is presented in Figure 6 and Figure 7. Racial and ethnic segregation in Cook County is well above national median levels (Henricks et al., 2017; Metropolitan Planning Council & Urban Institute, 2018). Cook County has concentrated areas of poverty, unemployment, and low life expectancy from decades-long systemic acts of discrimination, racist banking policies, and redlining against Black community members (Rothstein, 2017). Chicago has one of the most pronounced neighborhood-level disparities with a life expectancy gap exceeding 30 years within a 9-mile radius (National Center for Health Statistics, 2018). The consequences of this segregation are discussed further in the "Overview of health equity" chapter.

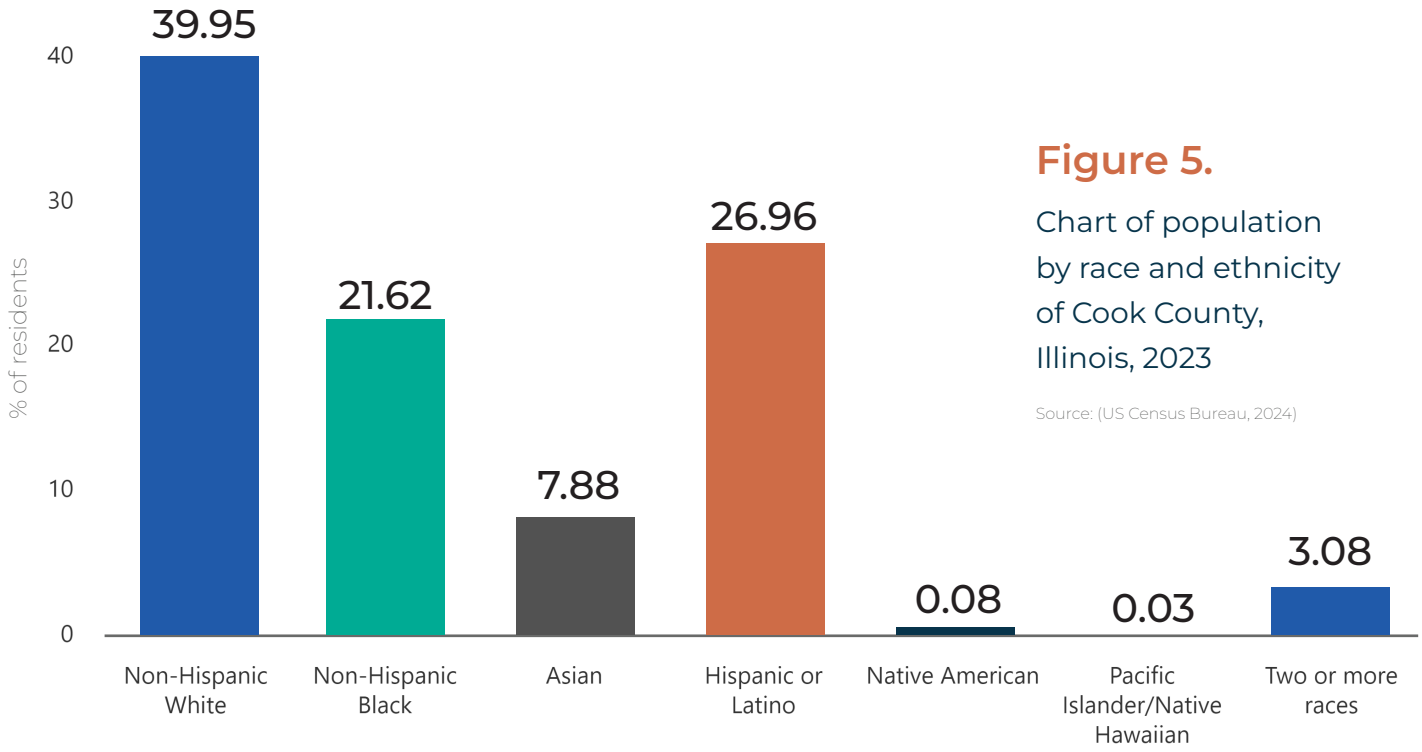


Figure 5.

Chart of population by race and ethnicity of Cook County, Illinois, 2023

Source: (US Census Bureau, 2024)

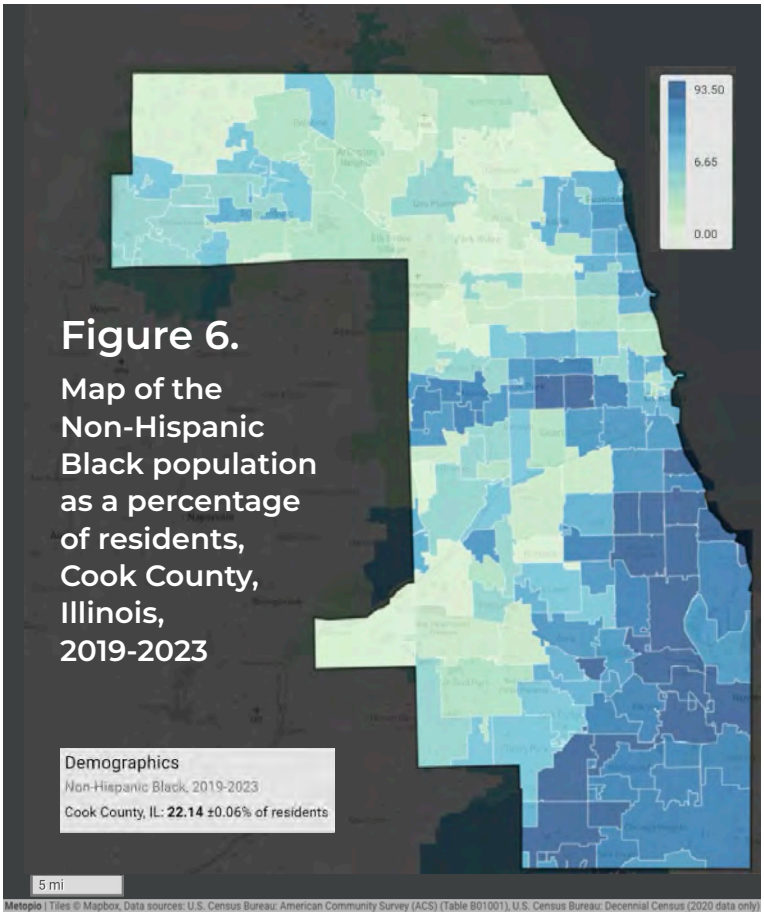


Figure 6.
Map of the Non-Hispanic Black population as a percentage of residents, Cook County, Illinois, 2019-2023

Source: (US Census Bureau, 2024)

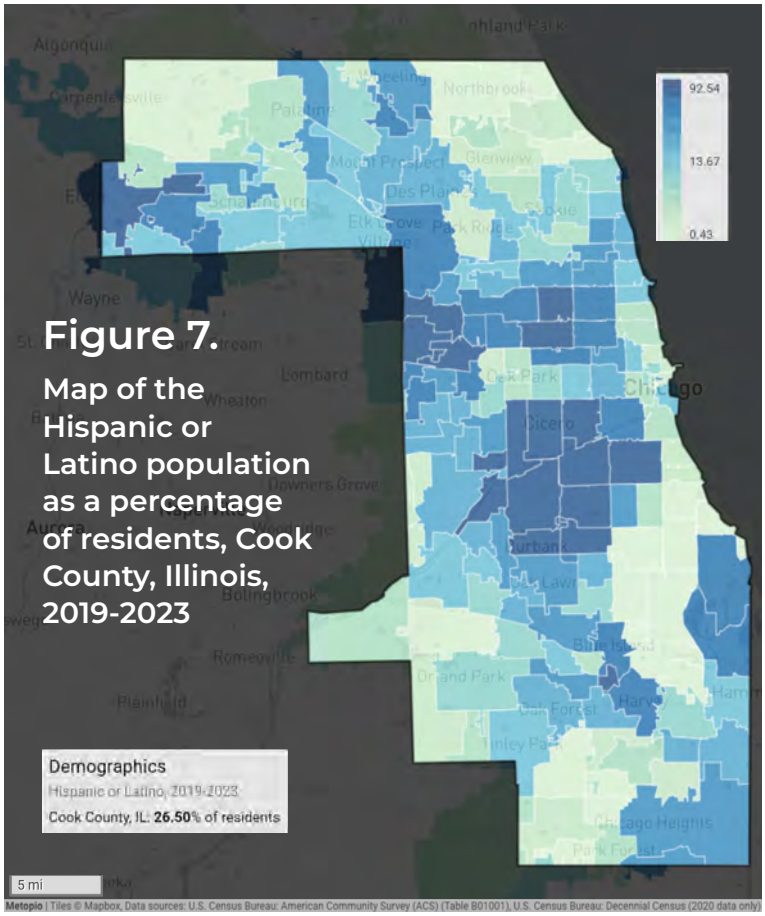


Figure 7.
Map of the Hispanic or Latino population as a percentage of residents, Cook County, Illinois, 2019-2023

Source: (US Census Bureau, 2024)

Immigration and English proficiency

In Cook County, 7% of households have limited English proficiency, comprising 14% of residents (US Census Bureau, 2024). As of 2022, an estimated 150,000 households speak a language other than English, and 71% of those limited English-speaking households speak Spanish (University of Illinois Urbana-Champaign College of Education, 2023). The languages that were spoken most frequently at home other than English were Spanish, Slavic, Chinese, Tagalog, and Arabic (University of Illinois Urbana-Champaign College of Education, 2023). There are multiple areas in Cook County where the population of limited English proficiency households were high (Figure 8).

Within Cook County, there are several communities with large concentrations of individuals that have limited English proficiency (Figure 8). A 2012 study in California found that individuals who reported limited English proficiency had low health literacy rates that were three times higher than English speakers (Sentell & Braun, 2012). In addition, individuals with both limited English proficiency and low health literacy reported the highest prevalence of poor health (45%), followed by limited English proficiency only (41%), low health literacy only (22%), and neither (14%) (Sentell & Braun, 2012). The study indicates that English proficiency has the potential to significantly impact health outcomes within immigrant communities.

Characteristics of households with children

In Cook County, 16% of households are married couples with children, mostly in the northern and northwestern suburbs (Figure 9). Single-parent households make up 6% of Cook County households, with the highest concentrations in the southern region of the county, particularly in Hazel Crest (18%), Robbins (16%), and Riverdale (23%) (Figure 10). Nine percent of children live with their grandparents, with the highest concentrations on the south and southeast sides of Chicago (Figure 11). These household patterns influence the demand for tailored community services.

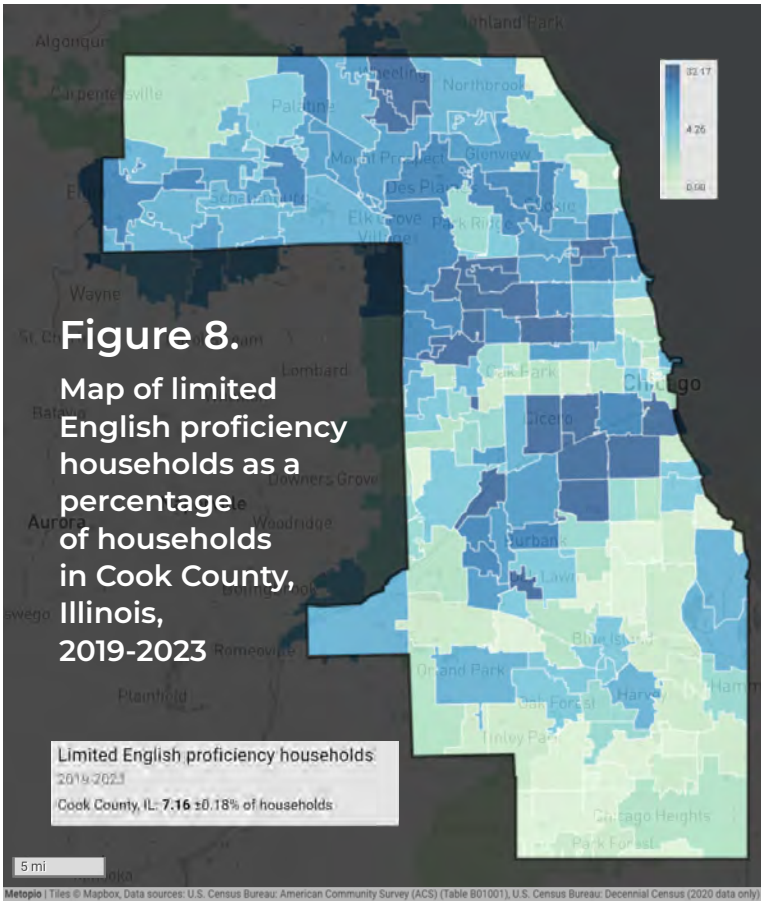


Figure 8.

Map of limited English proficiency households as a percentage of households in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

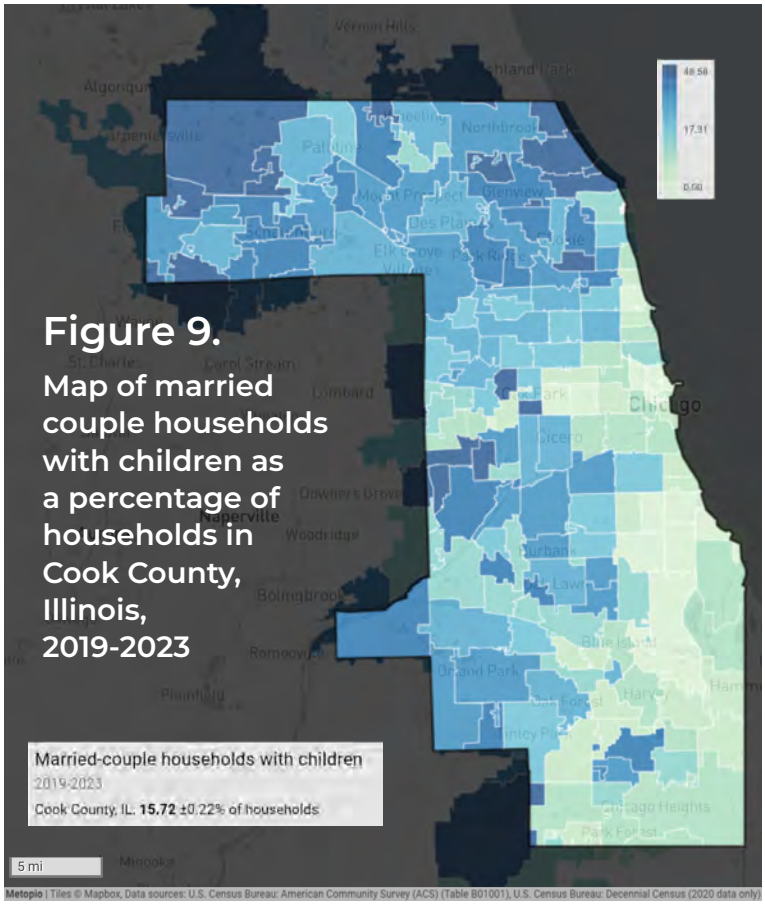


Figure 9.

Map of married couple households with children as a percentage of households in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

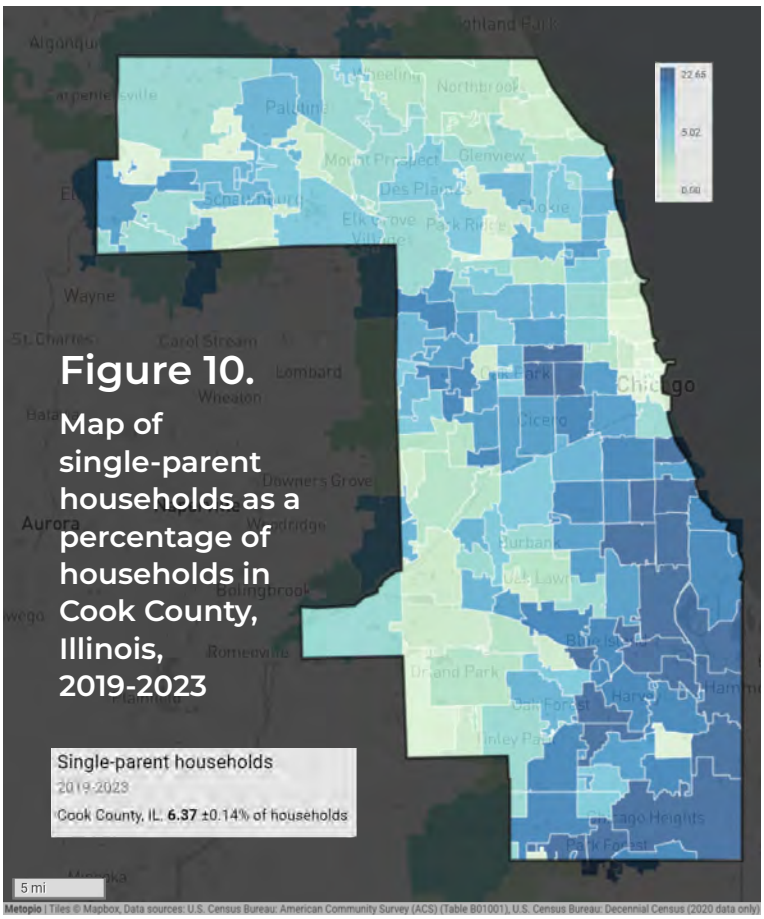


Figure 10.

Map of single-parent households as a percentage of households in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

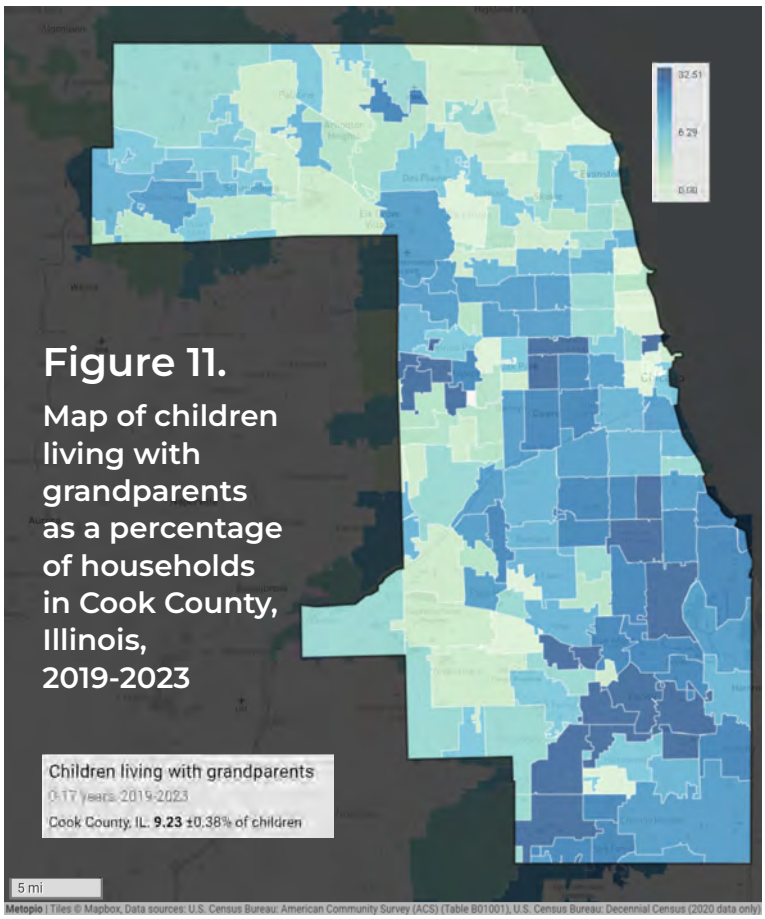


Figure 11.

Map of children living with grandparents as a percentage of households in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

Older Adults

A growing population of older adults living alone has significant implications for individuals, communities, and healthcare systems, with potential impacts on individual physical and mental health, community health, and the economy. In Cook County, 31% of adults aged 65 or older live alone, with high concentrations in Forest Park, Oak Park, and parts of Chicago, especially along Lake Michigan and the southeast side (Figure 12). This indicates a significant number of older adults in some communities may need additional support.

Individuals with Disabilities

As of 2023, 11% of Cook County residents are living with a disability, with higher prevalence in the south and southeast regions (Figure 13). However, data on resource accessibility for individuals with disabilities remains limited.

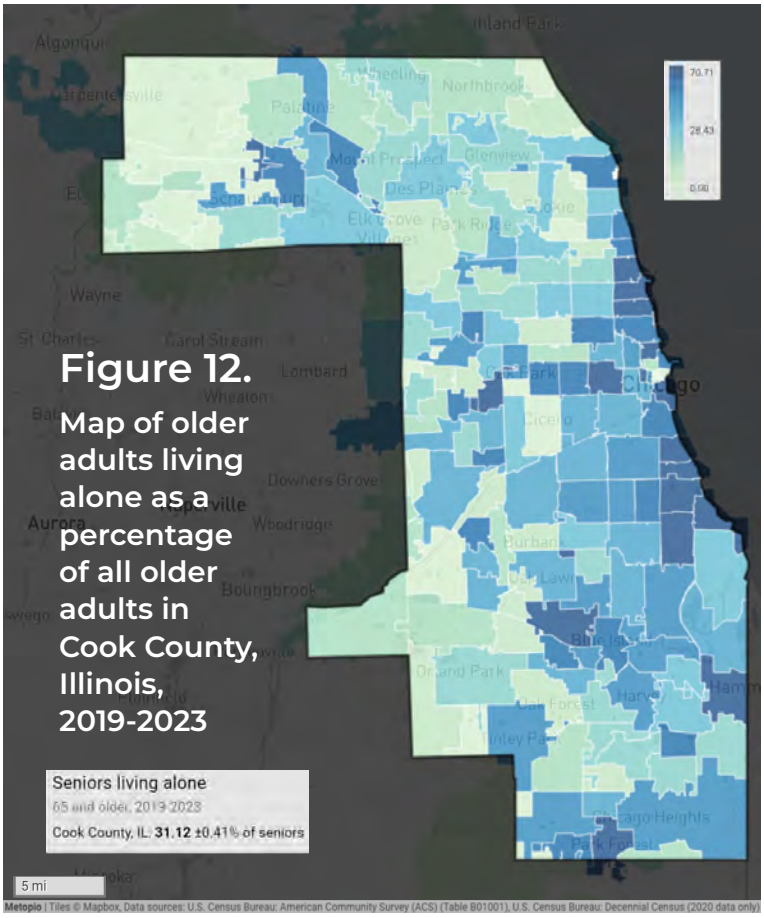


Figure 12.
Map of older adults living alone as a percentage of all older adults in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

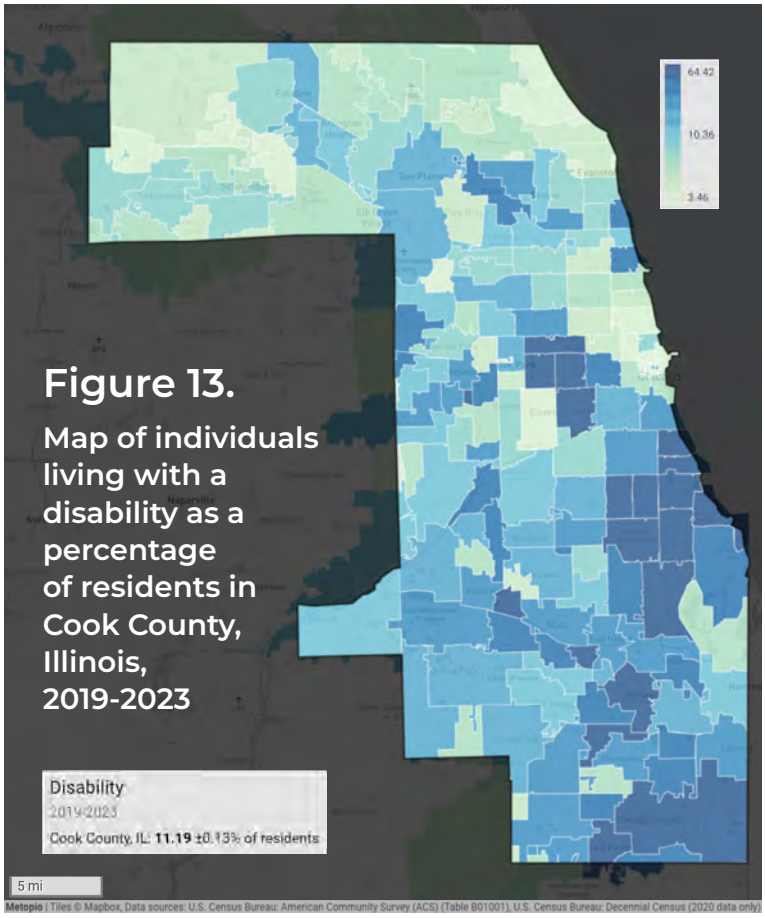


Figure 13.
Map of individuals living with a disability as a percentage of residents in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

SELF-REPORTED HEALTH STATUS

In 2022, 11% of adults in Cook County reported poor physical health (Figure 14). These issues were most prevalent in the southern parts of Suburban Cook County and Chicago. In 2022, 21% of adults in Cook County reported not exercising at all in the past month (Centers for Disease Control and Prevention, 2022b). Additionally, 15% of Cook County residents reported poor mental health (Figure 1), and similar to self-reported physical health issues, poor mental health was prevalent in southern suburban Cook County and the South Side of Chicago.

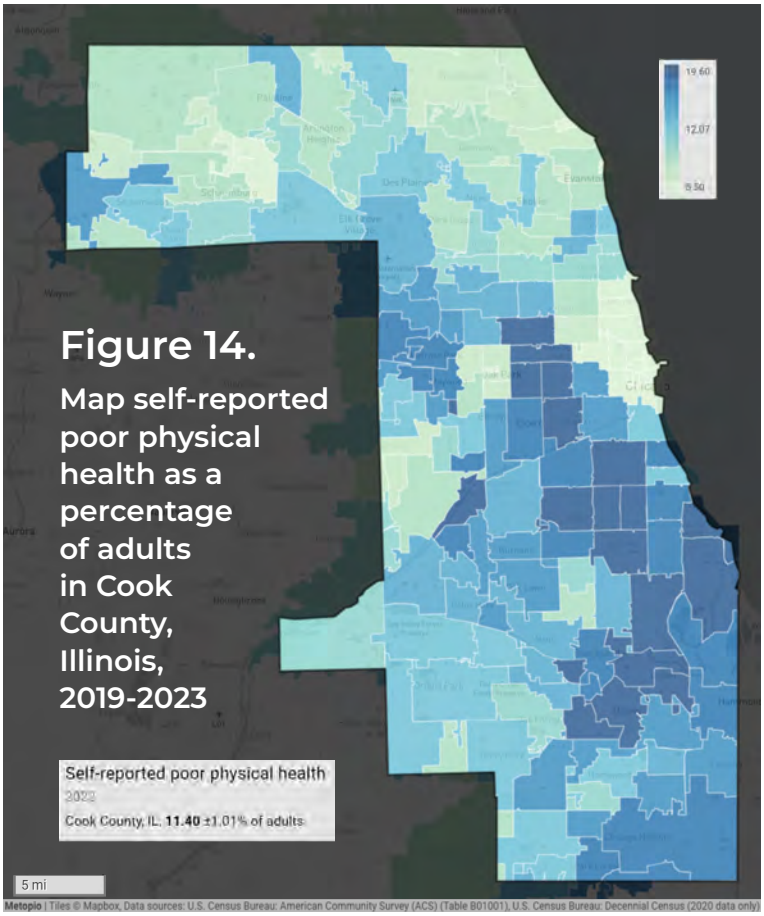


Figure 14.

Map self-reported poor physical health as a percentage of adults in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

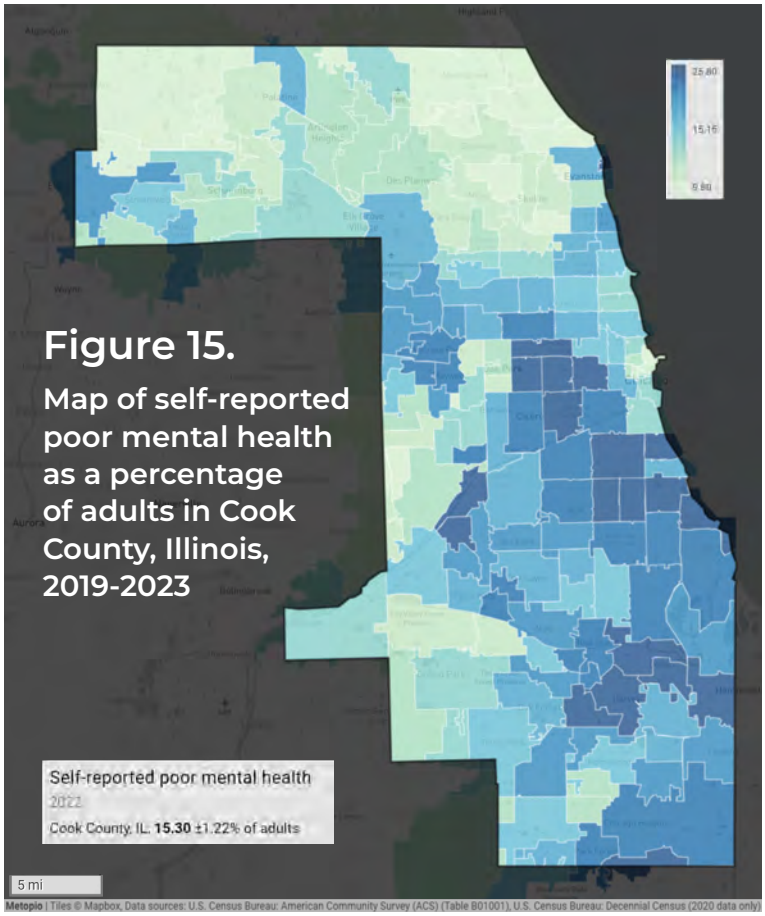


Figure 15.

Map of self-reported poor mental health as a percentage of adults in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

On the community input survey, respondents were asked to rate their personal health and the health of their community. Fifty-nine percent rated their personal health as healthy or very healthy while only 43% rated their community as healthy or very healthy (Figure 16 and Figure 17).

Figure 16.

Survey responses – How would you rate your personal health? (n=1862)

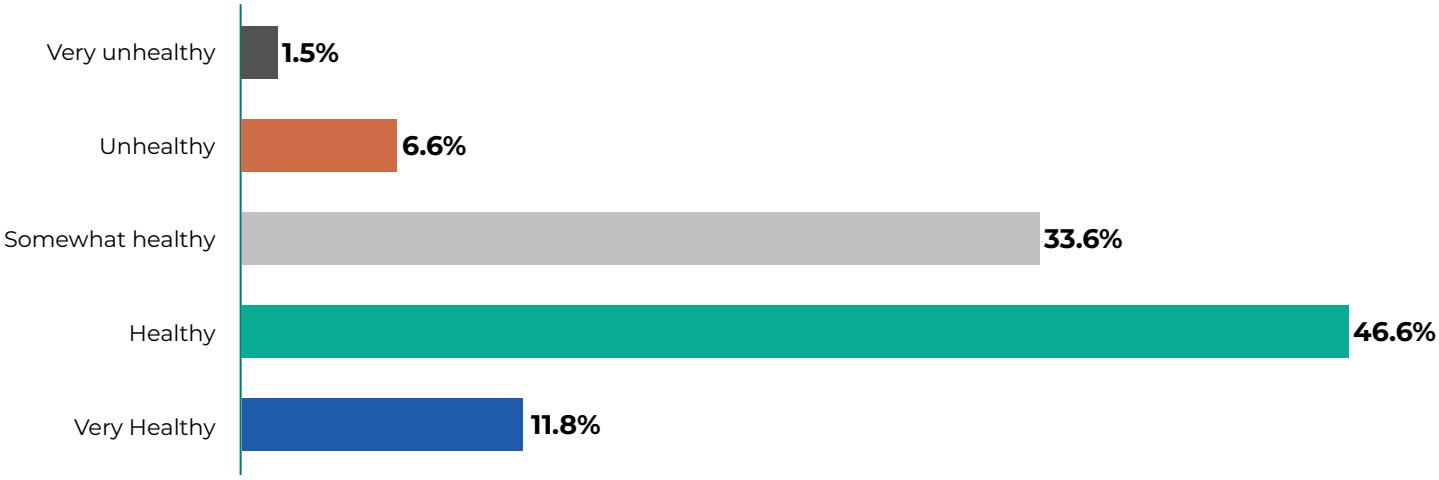
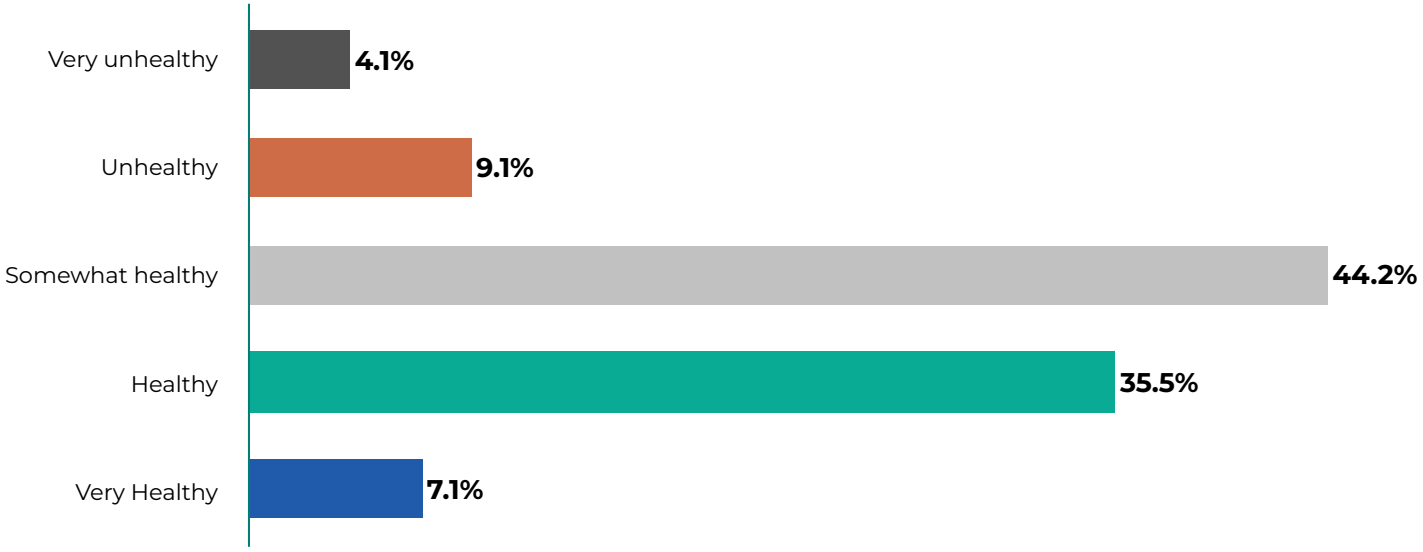


Figure 17.

Survey responses – How would you rate the overall health of your community? (n=1841)



PRIORITY POPULATIONS

The table below provides an overview of key demographic characteristics for historically marginalized and health equity priority populations in Cook County, Illinois (Figure 18). These groups include individuals experiencing homelessness, those involved in the justice system, people living with mental health conditions or substance use disorders, individuals with disabilities, immigrants and refugees, veterans and former military personnel, and youth. Understanding the unique challenges and needs of these populations is essential for promoting health equity and developing strategic interventions to improve community well-being.

Figure 18.

Table of priority populations in Cook County, Illinois

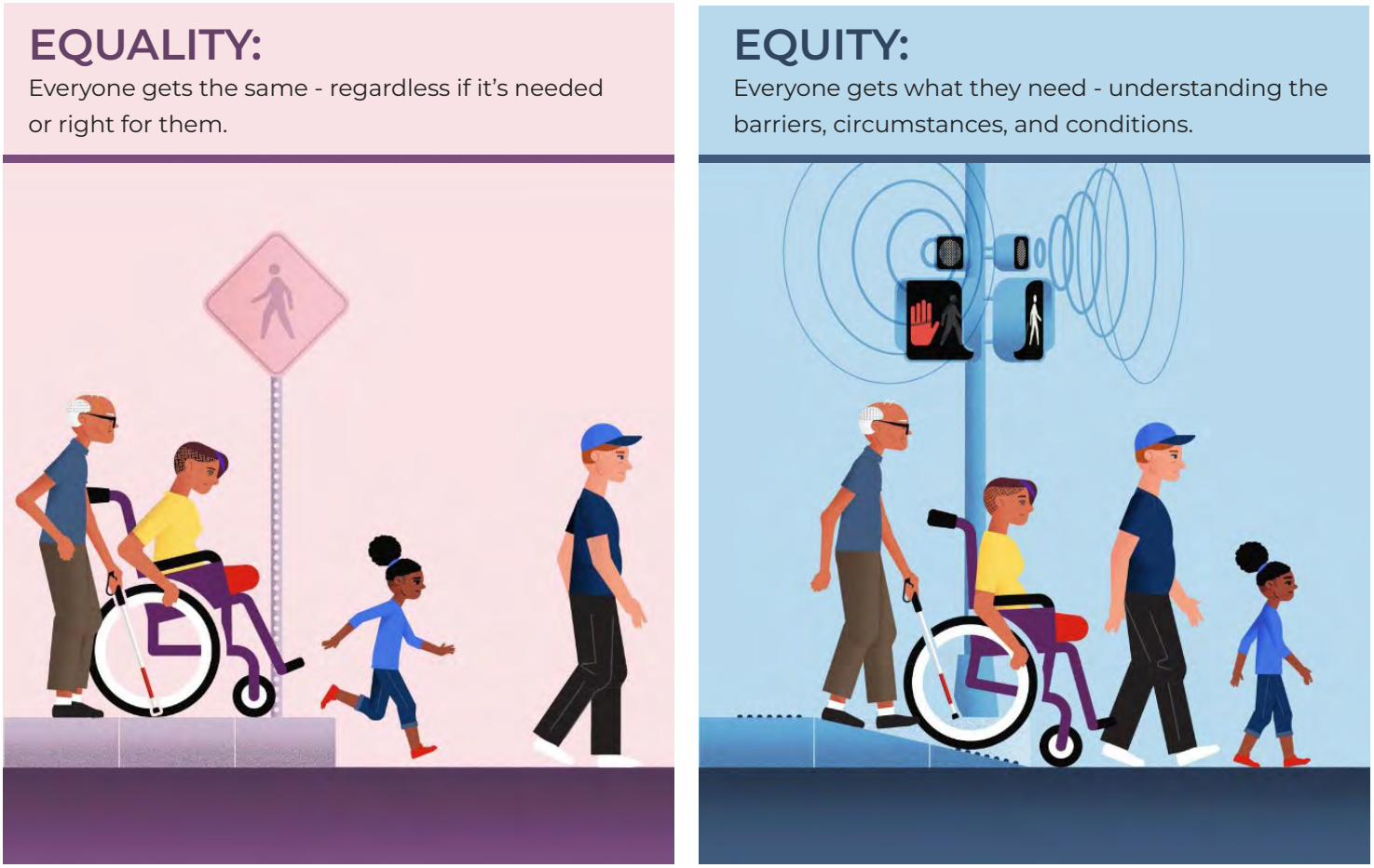
PRIORITY POPULATION	DEMOGRAPHIC CHARACTERISTICS
People experiencing homelessness	In 2023, the estimated homeless rate in Illinois was 95 individuals per 100,000. Approximately 11,950 individuals in Illinois experienced homelessness in 2023 (de Sousa & Henry, 2024). In 2022, the number of individuals experiencing homelessness in Cook County was estimated at 9,212 (U.S. Department of Housing and Urban Development, 2022). There are significant racial and ethnic inequities with the majority of the homeless population in Cook County being Black (Chicago Metropolitan Agency for Planning, 2021).
Justice-involved	Illinois has an incarceration rate of 236 per 100,000 people (Bureau of Justice Statistics, 2022).
People living with mental health conditions and substance use disorders	It is estimated that approximately 1,754,000 adults in Illinois are living with a mental health condition (National Alliance on Mental Illness, 2021). Despite this, Illinois's state mental health agency spending per capita on community treatment programs is low in relationship to the U.S. average (Heun-Johnson et al., 2018). In 2023, 58% of Americans who needed treatment for substance use disorder did not receive treatment (Substance Abuse and Mental Health Services Administration, 2023)
People living with a disability	Approximately 11% of people in Cook County are living with one or more disabilities (U.S. Census Bureau, American Community Survey, 2019-2023).
Immigrants and refugees	Approximately 10% of Cook County residents are non-citizens, and 11% are naturalized citizens (U.S. Census Bureau, 2023). In 2022, about 1.79 million foreign-born individuals comprised 14% of the population in Illinois, and 940,400 native-born people in Illinois (9%) reported at least one immigrant parent (American Immigration Council, 2022). In addition, 395,000 Illinois residents live with at least one undocumented family member, and undocumented immigrants composed approximately 27% of the immigrant population in 2022 (American Immigration Council, 2022).
LGBTQIA+	There are approximately 298,000 adults in Chicago who identify as LGBTQIA+, about 4.1% of the city's adult population (Conron et al., 2021). In addition, 30% of Chicago high schoolers identify as LGBTQIA+ (Centers for Disease Control and Prevention, 2024u).
Veterans and former military	An estimated 3% of the population in Cook County are veterans (U.S. Census Bureau, American Community Survey, 2019-2023).
Youth	Twenty-one percent of the population in Cook County is younger than18 years old (U.S. Census Bureau, American Community Survey, 2019-2023).

OVERVIEW OF HEALTH EQUITY

Health equity is generally defined as the state in which everyone has a fair and just opportunity to attain their highest level of health (Figure 19).

Figure 19.

The difference between equality and equity



Source: (Barlow, 2022) Copyright 2022 Robert Wood Johnson Foundation

Health inequities, also called health disparities, are differences in health between groups of people that are due to broader social inequities. Health inequities can exist across many dimensions such as race, ethnicity, gender, sexual orientation, age, disability status, socioeconomic status, geographic location, and military status (Centers for Disease Control and Prevention, 2025b). Figure 20 highlights examples of health inequities in Cook County.

Figure 20.

Examples of inequities in Cook County, Illinois

LIFE EXPECTANCY	Life expectancy is 70.2 years for Non-Hispanic Blacks and 87.3 years for Asians or Pacific Islanders living in Cook County.
INFANT MORTALITY	Black infants are approximately 2.6 times more likely to die than white infants, and Hispanic/Latine infants are about 1.2 times more likely to die than white infants in Cook County.
HOMELESSNESS	A Black person is about 5.5 times more likely to experience homelessness than a white person in Cook County.
AIR POLLUTION	Industries in the Toxic Release Inventory are concentrated near public schools in Chicago neighborhoods with predominantly Hispanic/Latine students.

Sources: (Illinois Department of Public Health, 2019; Joel Flax-Hatch et al., 2021; National Center for Health Statistics, 2021; Pett & Masinjila, 2024)

Four key principles highlight why it is essential to address health inequities.

1. **Inequities are unjust.** Health inequities result from the unjust distribution of the underlying determinants of health such as education, safe housing, access to healthcare, and employment.
2. **Inequities affect everyone.** Conditions that lead to health disparities are detrimental to all members of society and lead to loss of income, lives, and potential.
3. **Inequities are avoidable.** Many health inequities stem directly from government policies such as tax policy, business regulation, public benefits, and healthcare funding, and therefore, can be addressed through policy interventions.
4. **Interventions to reduce health inequities are cost-effective.** Evidence-based public health programs to reduce or prevent health inequities can be extremely cost effective, particularly when compared to the financial burden of persistent disparities (Centers for Disease Control and Prevention, 2025b; Weinstein et al., 2017)

As a result, the Alliance for Health Equity strives to increase health equity, improve health and quality of life, improve systems of care, and increase life expectancy for people living in Cook County through cross-sector collaboration, creating healthier communities, shared values, and strengthening integration of services across the public health system.

Racism, discrimination, and intersectionality

Race and ethnicity are social constructs that divide people based on their perceived physical traits such as skin color and facial features, or cultural factors such as language, religion, ancestry, and nationality. Historically, race and ethnicity have been used to marginalize and oppress certain groups of people while providing advantages to others. Racial and ethnic inequities are the most persistent health inequities in the United States (Weinstein et al., 2017), driven by the direct impacts of racism and discrimination on the social and economic influencers of health (Figure 21).

Figure 21.

Health inequities among racial and ethnic groups are driven by racism and discrimination, which directly affect social and economic factors influencing health

Source: (Ndugga et al., 2024)

Racism shapes opportunities and assigns value based on appearance or culture, creating unfair advantages for some and disadvantages for others (American Public Health Association, 2024). Racism harms our nation's health by denying some people the chance to reach their full health potential and drives inequities in social determinants of health (American Public Health Association, 2024). Racism can be unintentional or intentional and operates at several different levels. Figure 22 illustrates the framework used by the Alliance for Health Equity to understand the different types of racism that often interact and operate simultaneously. The framework separates individual and systemic racism to emphasize the need for institutional and structural changes to achieve racial justice and health equity (Race Forward, 2023). Tackling individual racism alone cannot dismantle structural racism (Race Forward, 2023).

One major consequence of racism in Cook County is segregation. As one of the most segregated regions in the United States, the Chicago area has a long history of racial and economic segregation. Segregation is a system of formal and informal policies that enforce the separation of different groups, usually along racial or economic lines. Segregation creates disparities in access to housing, education, economic opportunities, services, and healthcare. If the Chicago area were to be reduced to the national median level of segregation the region's gross domestic product (GDP) would increase by approximately $8 billion and the incomes of Black communities would rise by an average of $2,982 per person per year (Metropolitan Planning Council & Urban Institute, 2018).

Figure 22.

Institutional and structural changes are needed to achieve racial justice and health equity

INDIVIDUAL RACISM

Internalized racism

lies *within individuals*. These are private beliefs and biases about race that reside inside our own minds and bodies. For white people, this can be internalized privilege, entitlement, and superiority; for people of color, this can be internalized oppression. Examples: prejudice, xenophobia, conscious and unconscious bias about race, influenced by the white supremacy.

Interpersonal Racism

occurs *between individuals*. Bias, bigotry, and discrimination that is based on race. Once we bring our private beliefs about race into our interactions with others, we are now in the interpersonal realm. Examples: public expressions of prejudice and hate, microaggressions, bias and bigotry between individuals.

SYSTEMIC RACISM

Institutional racism

occurs *within institutions*. It involves unjust policies, practices, procedures, and outcomes that work better for white people than people of color, whether intentional or not. Example: A school district that concentrates students of color in the most overcrowded, under-funded schools with the least experienced teachers.

Structural racism

is racial inequities *across institutions*, policies, social structures, history, and culture. Structural racism highlights how racism operates as a system of power with multiple interconnected, reinforcing, and self-perpetuating components which result in racial inequities across all indicators for success. Structural racism is the racial inequity that is deeply rooted and embedded in our history and culture and our economic, political, and legal systems. Examples: The "racial wealth gap," where Whites have many times the wealth of people of color, resulting from the history and current reality of institutional racism in multiple systems.

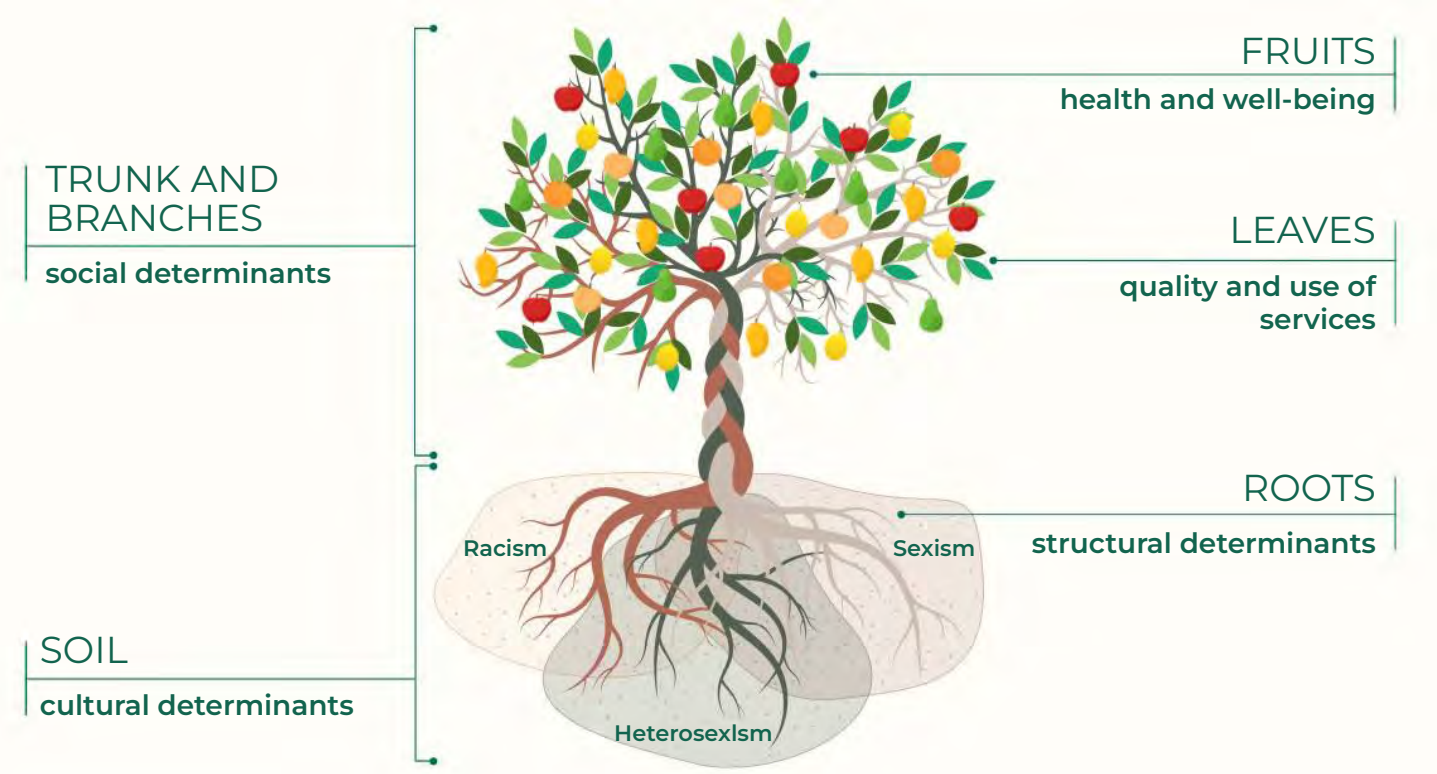
Source: (Race Forward, 2023)

Intersectionality

Intersectionality refers to how categories like race, age, class, gender, ability, and sexual orientation combine to create overlapping systems of discrimination and disadvantage for marginalized groups (Figure 23). This compounded discrimination and disadvantage leads to poorer health outcomes for people with multiple marginalized identities. Figure 24 highlights nationwide examples of how intersectionality impacts social and economic influencers of health. By applying an intersectional lens to this assessment, the Alliance for Health Equity aims to develop multidimensional strategies to address the social and economic influencers of health.

Figure 23.

Intersectionality and its influence on health*

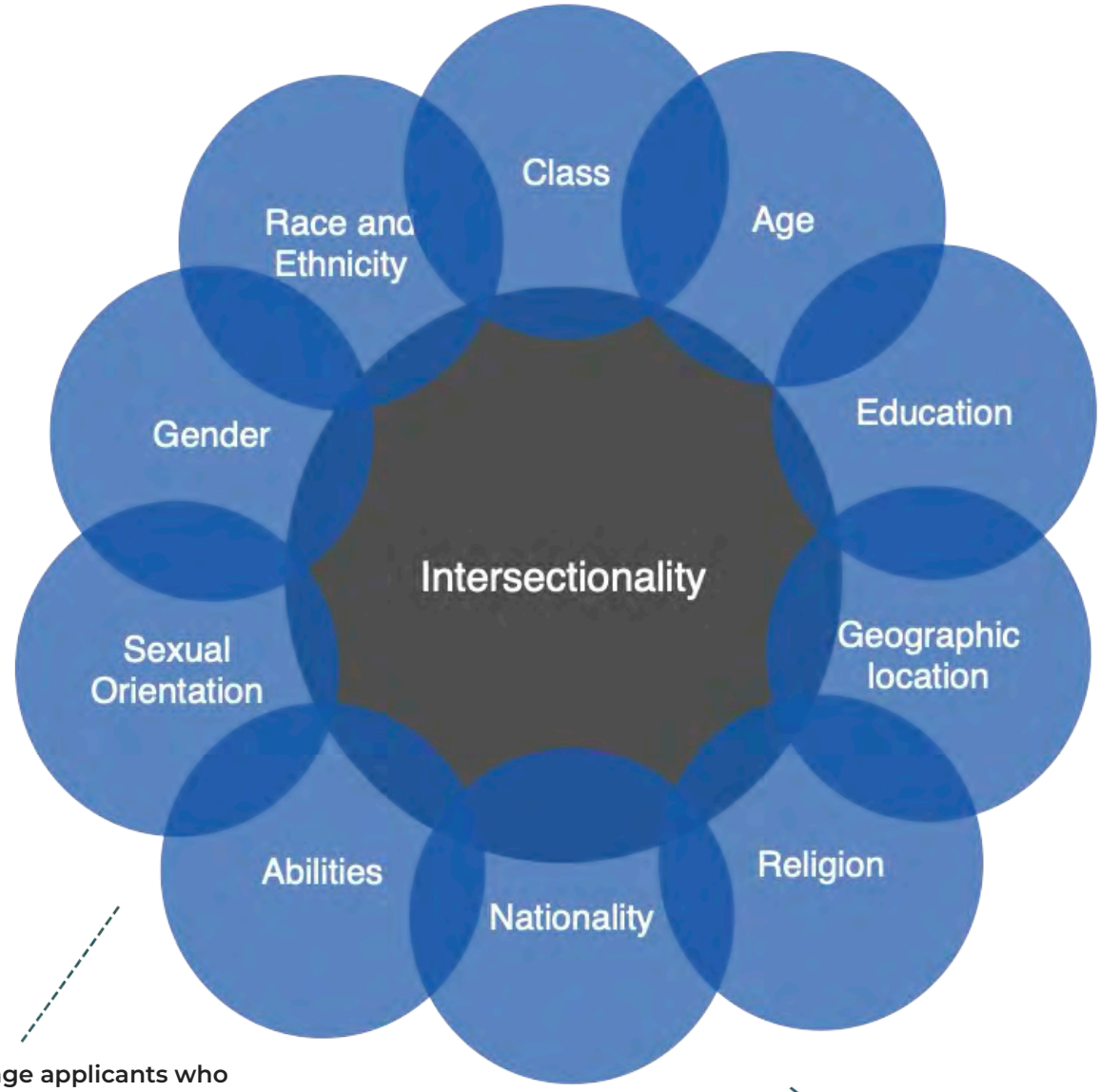


* This graphic focuses on racism, sexism, and heterosexism to provide a clear illustration, recognizing that this is an oversimplification of intersectionality and how it operates. Systems of oppression not pictured here include, but are not limited to, classism, ageism, ableism, fatphobia, ethnocentrism, colorism, and cisgenderism.

Source: (Michaels et al., 2021)

Figure 24.

Examples of intersectionality and its impact on the social and economic influencers of health



Mortgage applicants who are Black and/or in a same-sex partnership face higher rates of home mortgage denials than white and heterosexual buyers, even with the same income levels.

Black and Latina workers earn disproportionately lower wages than their male and white counterparts. The wage gap for LGBTQIA+ workers of color is even higher.

Uninsured Asian women are four times more likely to face barriers to accessing healthcare than privately insured white women, 3.2 times more likely than publicly insured white women, and 1.5 times more likely than uninsured white women.

Sources: (Bleiweis et al., 2021; Human Rights Campaign Foundation, 2021; Sun & Gao, 2019; Vohra-Gupta et al., 2023)

Implications

Health inequities affect individuals and communities in many different ways. For example, most preventable chronic diseases are tied to risk behaviors like smoking, poor nutrition, physical inactivity, and excessive alcohol use (Centers for Disease Control and Prevention, 2024a). These behaviors are influenced by the environments where people are born, live, work, and age, which shape opportunities for healthy choices and access to medical care (Centers for Disease Control and Prevention, 2024a; K. Hacker, 2024). In the United States, inequities in social determinants of health, driven by racism and discrimination, have resulted in higher chronic disease burdens among low-income communities, marginalized racial and ethnic groups, people with disabilities, those with lower education levels, and uninsured populations. Addressing the social determinants of health is essential to reducing chronic disease rates.

Given the effects that health inequities have on the well-being of individuals, communities, and society, the Alliance for Health Equity has made preventing and reducing health inequities its primary focus since its inception. As a result, this assessment focused on identifying, naming, and building strategies to address the underlying root causes of health inequities including structural racism, discrimination, historical trauma, and the unjust distribution of resources.

SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH

Social and structural determinants of health (SDOH), also known as the social influencers of health, significantly influence health, well-being, and quality of life. As previously mentioned, these include factors like housing, education, income, access to healthy foods, exposure to pollution, and exposure to discrimination and racism. SDOH also drive health inequities; for example, limited access to nutritious food increases the risk of conditions like diabetes and heart disease, reducing life expectancy. Addressing these inequities requires going beyond promoting individual healthy choices and necessitates coordinated system-level efforts across sectors like education, housing, and transportation.

POVERTY

Poverty can negatively impact health by limiting access to high quality healthcare, healthy foods, stable housing, and other necessities. A history of keeping Black and Brown people out of certain neighborhoods in Chicago and Cook County suburbs, in addition to not investing in improving their quality of living, has kept individuals in poverty. This has led to a decrease in Chicago's Black population (Pappas, 2022). In 2023, Chicago had a slightly higher portion of individuals living below 200% of the Federal Poverty Level (33%) compared to Cook County residents (28%) (US Census Bureau, 2024). As of 2023, 8% of the population of Chicago, or about 211,000 Chicagoans, live in deep poverty, which is households with an income 50% below the poverty threshold (US Census Bureau, 2024). In Chicago,individuals in single-mother households (18%), Black Chicagoans (16%), and children under 18 (14%) were some of the groups where the deep poverty rate was high (US Census Bureau, American Community Survey, 2024). In Cook County, 19% of children were living in poverty. In 2021, over 45,000 older adults in Suburban Cook County lived in poverty (AgeOptions, 2022).

Participants in the community focus groups have expressed difficulty accessing necessities, especially on the South Side of Chicago. Several people conveyed that they are unsatisfied with their quality of living, citing multiple factors such as living in a food desert, burdening medical expenses, lack of public transportation options, and other day-to-day stressors. Even though there is programming being implemented by Chicago hospitals to make sure South Side residents are connected to resources, focus group participants emphasized the importance of making sure that communication is reaching the intended community.

INCOME

The per capita income for Chicago is $46,798, and the median household income is $74,474 (Figure 25). For Cook County, the per capita income is $46,931, and the median household income is $80,579 as of 2023 (Figure 25). Looking at the northeastern suburbs Figure 26, where the median income ranges as high as $250,000, and contrasting it with the west side of Cook County, where the median income is as low as $16,611, economic disparity is apparent. This disparity is similarly shown within Chicago where the median income in most North Side zip codes is higher than the zip codes in South Figure Figure 27).

Figure 25.

Table of per capita and median household income in Chicago, Illinois, 2023

	CHICAGO	COOK COUNTY
Median household income	$74,474	$80,579
Per capita income	$46,798	$46,931

Source: (US Census Bureau, 2024)

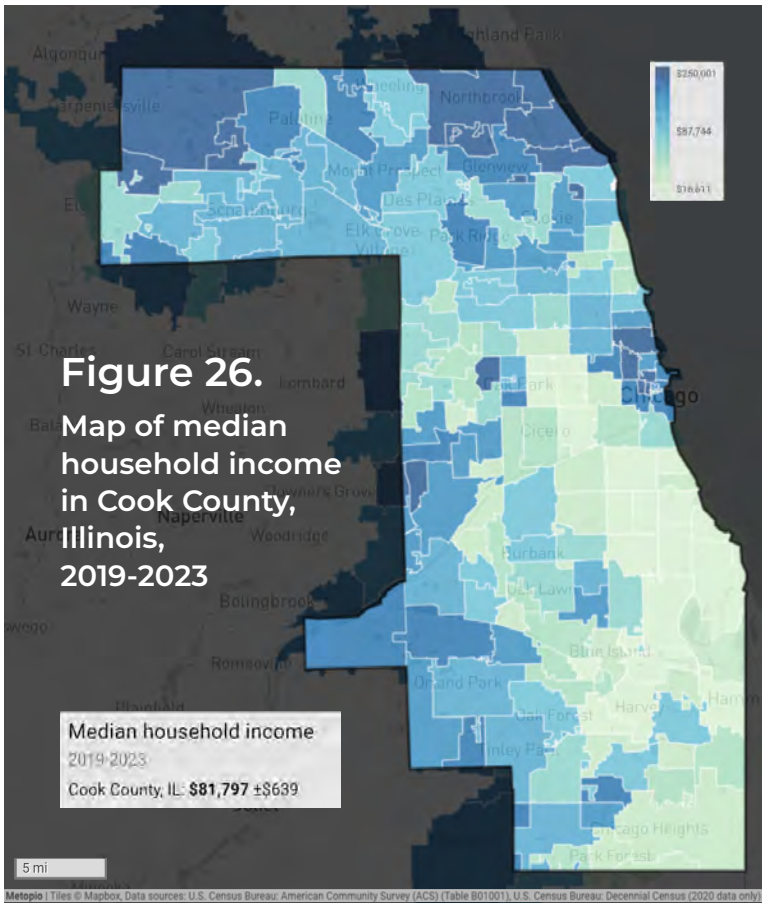


Figure 26.
Map of median household income in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

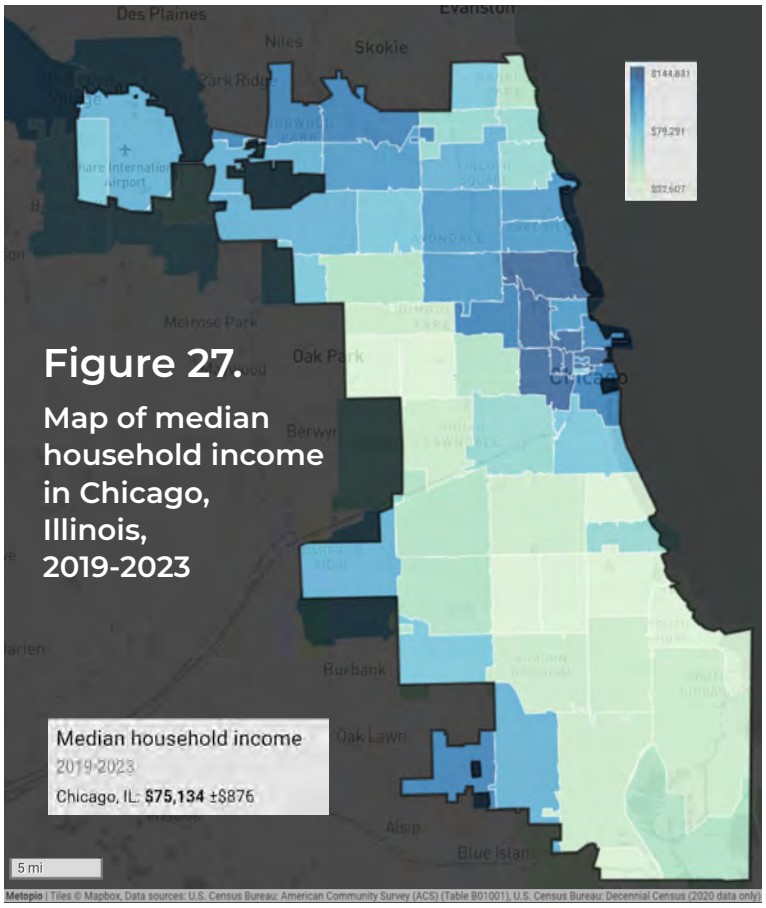


Figure 27.
Map of median household income in Chicago, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

EMPLOYMENT

Unemployment and underemployment can create financial instability, which influences access to healthcare services, insurance, healthy foods, stable quality housing, and other basic needs. Unemployment and underemployment in Chicago and Suburban Cook County are often associated with a history of disinvestment and economic segregation. In the mid- to late-20th century, many of the southern and western regions of the city were thriving due to factory employment. As the factory industry moved to lower cost locations, job opportunities moved, too. The disinvestment in Chicago and Suburban Cook County created a gap in employment opportunities that still has not been closed and has been emphasized by the effects of the COVID-19 pandemic (Henricks et al., 2017; Wilson & Sepulveda, 2024). The most recent unemployment rates in Cook County (6.88%), Chicago (7.92%), and Illinois (5.8%) are slightly higher than the rates for the United States. (5.2%) (Figure 28). The persistent geographic inequities in unemployment are visible in Figure 29.

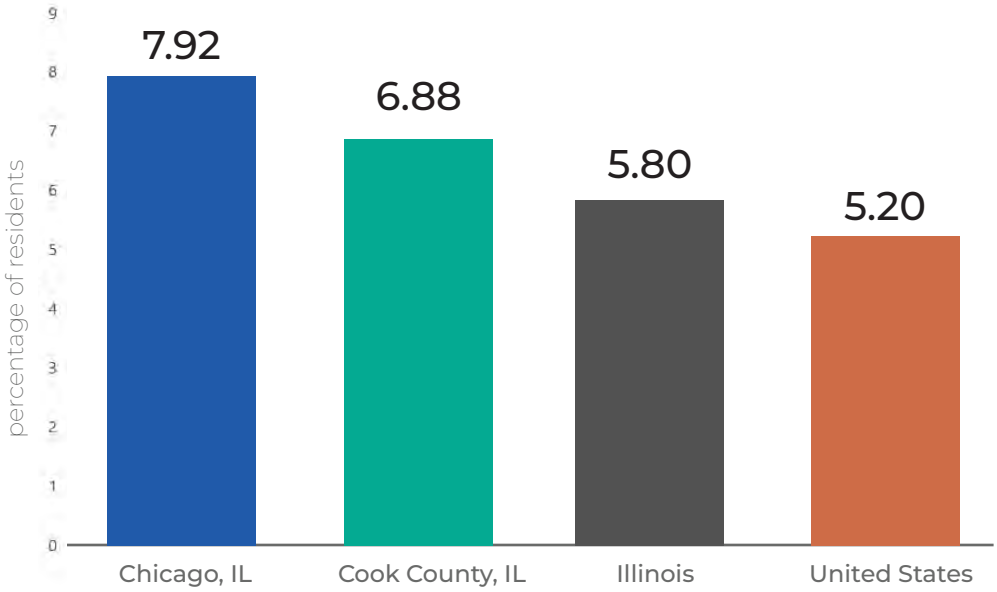


Figure 28.

Chart of unemployment rate as a percentage of residents in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

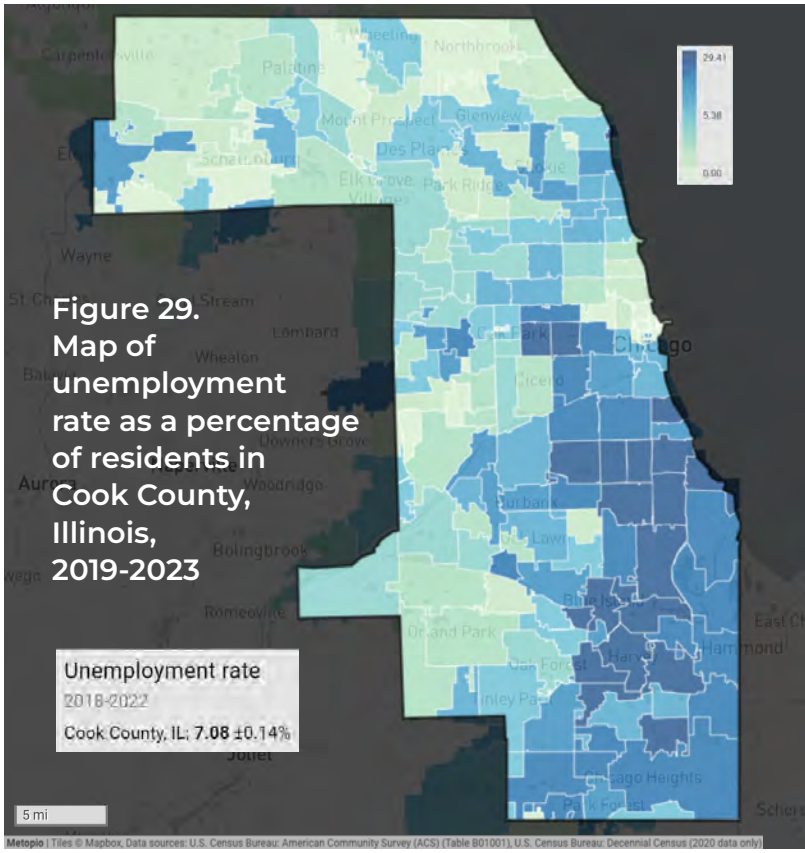


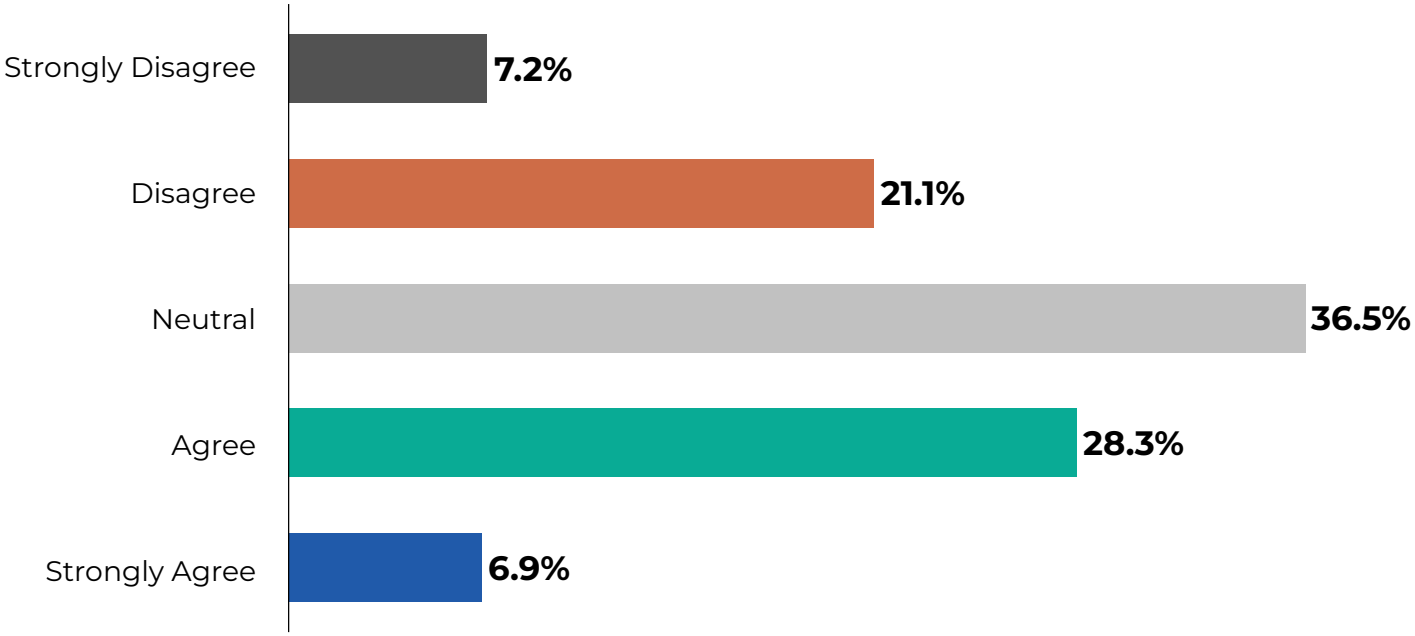
Figure 29. Map of unemployment rate as a percentage of residents in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

Community focus group participants highlighted the importance of economic opportunity for creating healthy communities. They cited the need for workforce development, especially for Black and Brown communities, youth, and immigrants and refugees. Seventeen percent of community input respondents reported the need for workforce and employment opportunities and 27% of respondents agreed with the statement, "there is economic opportunity in my community" (Figure 30).

Figure 30.

Survey responses – Agreement with the statement,
"There is economic opportunity in my community." (n=1843)



The COVID-19 pandemic increased unemployment, especially for youth and young adults. Employment recovery in Chicago lagged Illinois and the United States (Wilson & Sepulveda, 2024). Additionally, it was found that Black and Latine youth and young adults experienced close to no job recovery toward pre-pandemic employment levels (which could lead to new disparities in the city and county Figure and Figure give a visual of the jobless rates for ages 16–19-year-olds and 20–24-year-olds in Cook County.

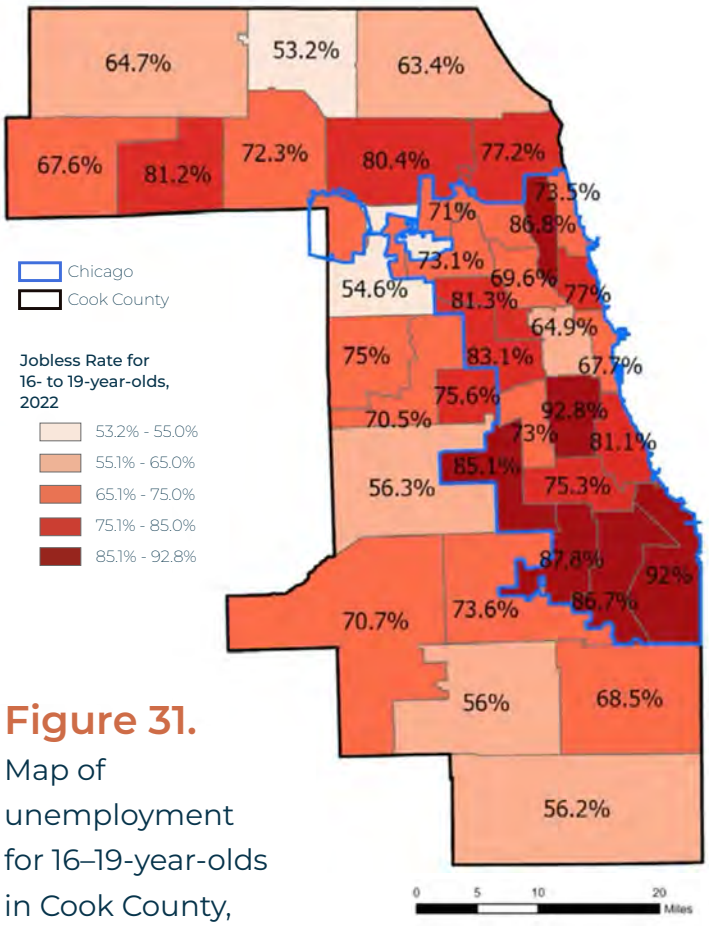


Figure 31.

Map of unemployment for 16–19-year-olds in Cook County, Illinois, 2022

Dala source: 2022 American Community Survey public use files
Map crealed by Great Cities Instltute.

Source: (Wilson & Sepulveda, 2024)

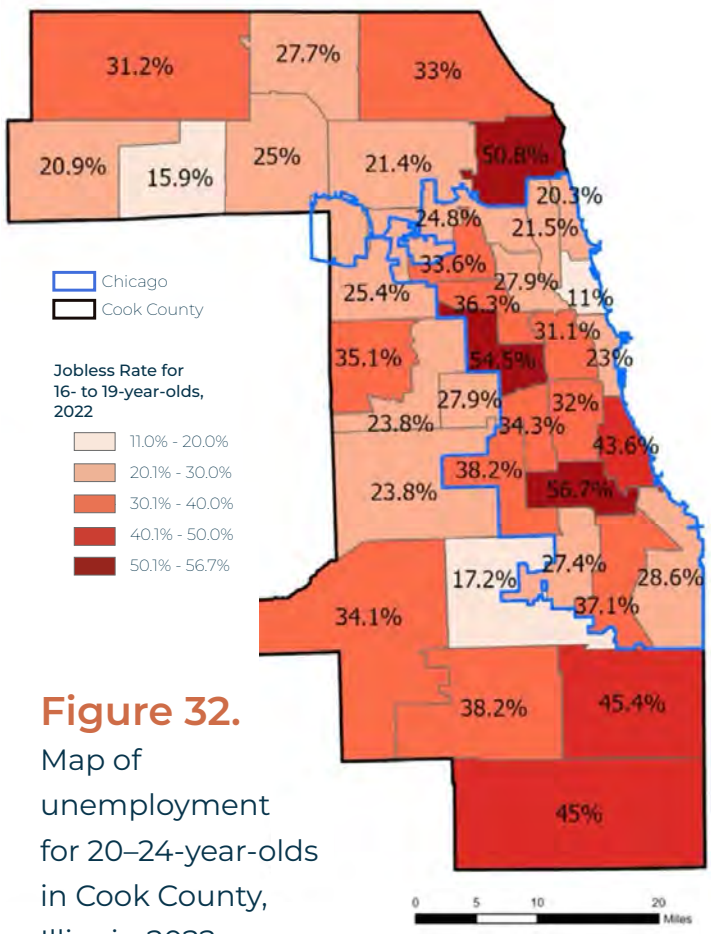


Figure 32.

Map of unemployment for 20–24-year-olds in Cook County, Illinois, 2022

Data source: 2022 American Community Survey public use files
Map created by Great Cities Institute.

Source: (Wilson & Sepulveda, 2024)

In focus groups, participants indicated that one of the impacts of the pandemic has been increased difficulty finding positions. On top of this job-hunting stress, focus group participants expressed that relying on employment to get health insurance is challenging; medical care is already expensive, so having a job tied to the quality of healthcare adds another layer of stress to their day-to-day life. Several of the participants also noticed that youth cannot access resources to help them identify career interests. As mentioned before, participants suggested more workforce development for youth, as well as not having healthcare tied to one's employment, as possible solutions to address employment and health challenges.

HOUSING

For many people in this country, housing can offer a pathway to better health, education, and businesses. However, for some people, housing (or the lack of it) is linkted to health inequities that have been sustained for decades due to systemic racism, government-fostered segregation, and discriminatory policies and practices (Swope & Hernández, 2019).

Community input emphasized the importance of affordable and safe housing in communities. Focus group participants have noticed the effect that gentrification has on rising rent prices; they commented that high housing prices push residents to places where public transportation and community services are less accessible. Focus group participants noted that it has been difficult for immigrants and refugees to move into the city due to unaffordable rent prices.

The majority of individuals experiencing homelessness are classified as low-income. In 2022, about 76,375 Chicagoans experienced homelessness, including more than 20,000 children (Figure 33). People experiencing homelessness include people who were temporarily staying with others and people living on the street and/or shelter. As seen in Figure 34 the Black population is disproportionately experiencing homelessness and housing instability.

Figure 33.

Chart of count of people experiencing homelessness by age in Chicago, Illinois, 2022

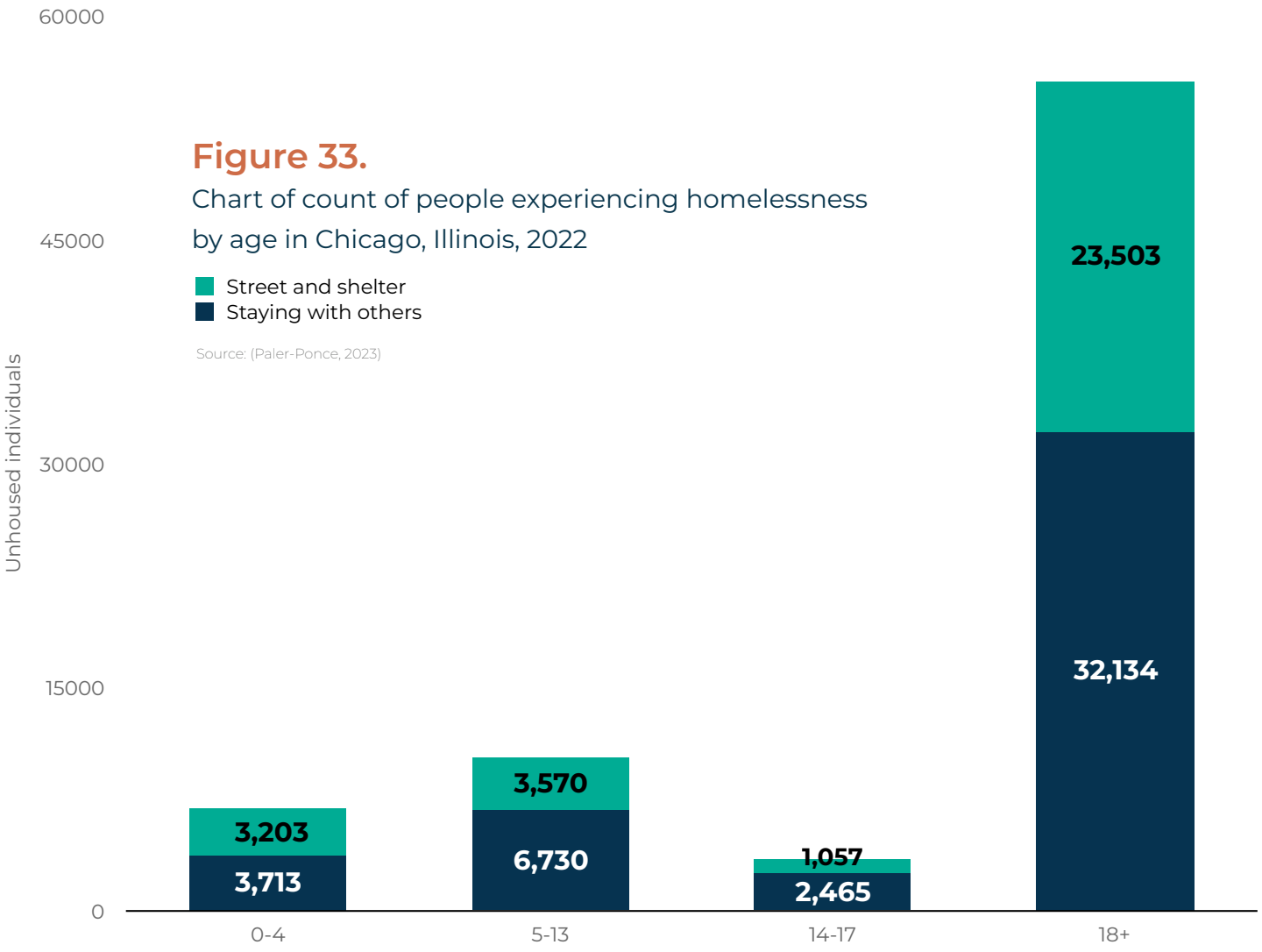
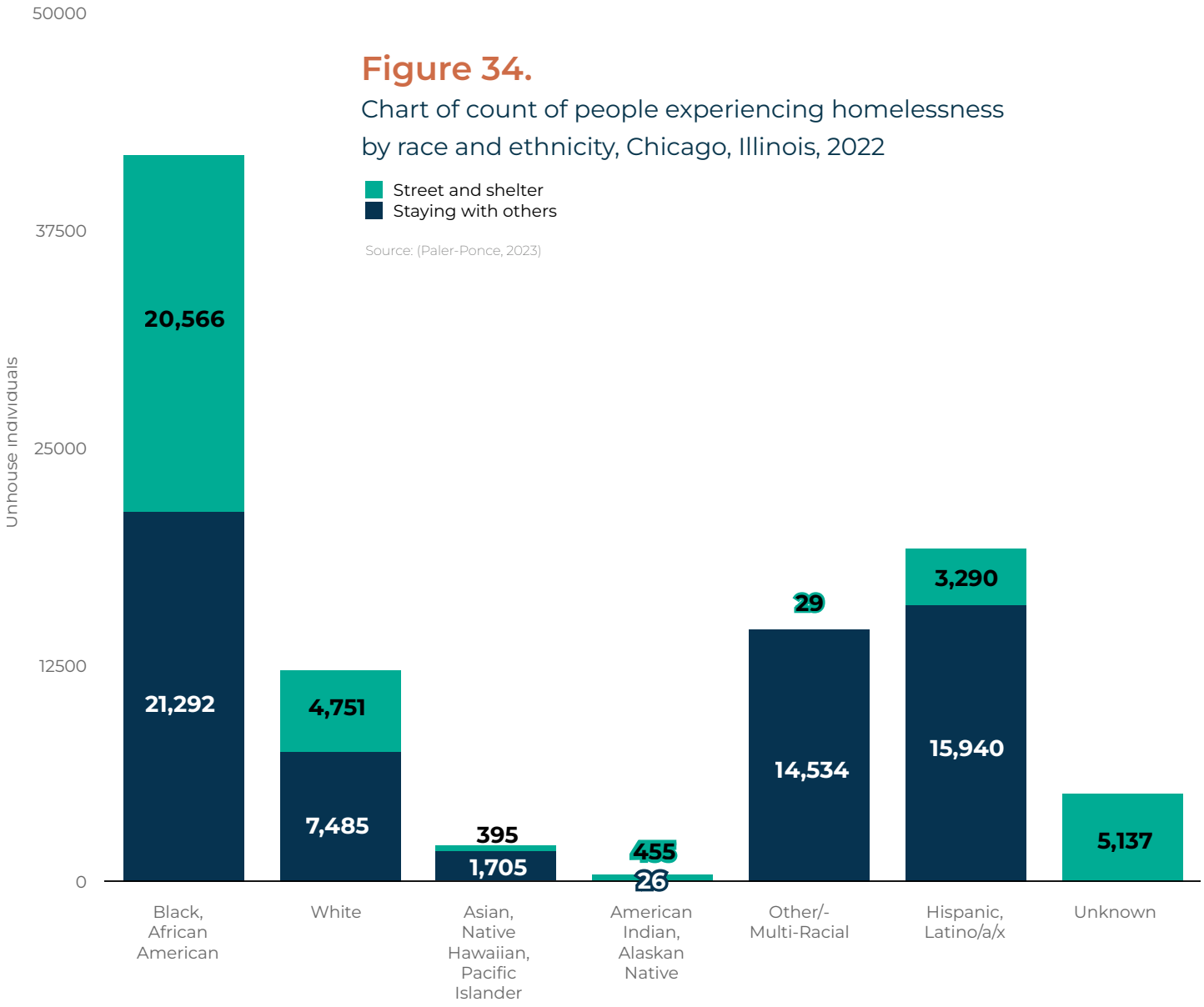


Figure 34.

Chart of count of people experiencing homelessness by race and ethnicity, Chicago, Illinois, 2022



Since August 2022, more than 41,000 migrants from the South and Southwest parts of the United States have arrived to Chicago (City of Chicago Department of Family and Support Services & City of Chicago Department of Housing, 2024). These individuals needed affordable housing, work documents, medical care, and more. In 2024, an estimated 18,836 people experienced homelessness in shelters or unsheltered locations, a big increase from 2023 when 6,139 people were reported as experiencing homelessness. Given this reality, along with the end of pandemic-era support and the continuing decline in affordable housing, Cook County communities have expressed a need for stable housing resources (City of Chicago Department of Family and Support Services & City of Chicago Department of Housing, 2024).

Eighteen percent of community input survey respondents identified homelessness and housing instability as one of the biggest issues in their community.

For years, various studies have found a connection between stable housing and health. Unstable housing can lead to homelessness, which can have negative impacts on one's physical and mental health (Centers for Disease Control and Prevention, 2024c). These burdens are not distributed equally across racial groups, with Black and Brown communities being more affected by housing instability, homelessness, and inequitable access to housing. In Illinois, Black people are eight times more likely to experience homelessness than white people. (Arenas et al., 2024).

There are several ways housing affects health and well-being. It is important to understand this relationship to promote equitable housing standards and sustain existing services (Swope & Hernández, 2019). Figure 35 provides a model that includes the following four pillars which explain how housing impacts health inequities:

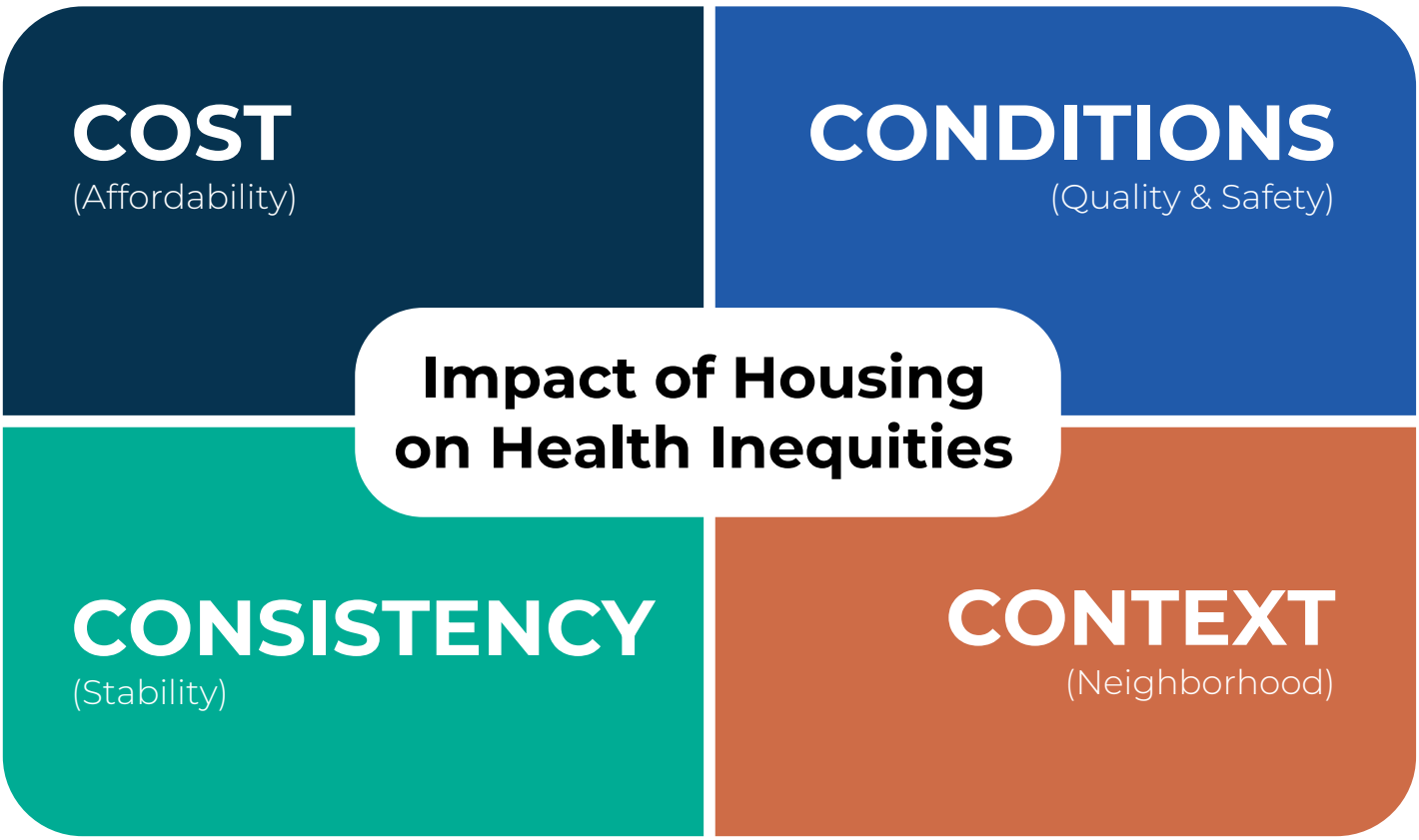
- cost (housing affordability), i.e. whether residents can pay the cost of the housing without burden
- conditions (housing quality and safety), i.e. the adequacy of physical hardware and environmental conditions of the building and unit
- consistency (residential stability), i.e. residents' ability to remain in their homes for as long as they desire
- context (neighborhood opportunity), i.e. the presence of positive or adverse health-relevant resources in the surrounding neighborhood (Swope & Hernández, 2019).

This model will be used as a guiding point when talking about how housing issues impact the health of Cook County communities.

Figure 35.

Model of the impact of housing on health inequities

Source: (Swope & Hernández, 2019; Taylor, 2018)



Housing cost burden

Affordable housing options are in short supply nationwide. In Cook County, 35% of occupied housing units spend 30-50% of their income paying rent and utilities, which indicates that housing costs are a burden — households spending more than 30% of their income on housing are considered cost burdened, and severely cost-burdened households have 50% or more of their monthly gross income devoted to housing; within Cook County, the portion of rental households with high-cost burdens is 49.2% (US Census Bureau, American Community Survey, 2024). (US Census Bureau, American Community Survey, 2024). Figure 36 includes both renters (rent) and owners (mortgage and other owner costs) to calculate the cost-burdened households in Cook County.

Housing affordability can significantly affect a person's ability to pay for food, medical care, public transportation, and other wraparound services. When households struggle to afford rent, mortgage, tax, or utility bills, they are more at risk for adverse health outcomes because they must decide between housing and seeking healthy foods, paying transportation costs, and much more (Bushman & Mehdipanah, 2022).Without an adequate housing stock, many people are at risk of starting or continuing a cycle of homelessness.

Housing in Cook County has been a racial equity issue for a long time. Communities of color have disproportionately experienced housing instability, homelessness, and low ownership rates. Black and Hispanic/Latine communities often have very high property taxes on low property values, and their median household wealth is much lower (Robert Wood Johnson Foundation, 2019). This leads to a rising number of evictions and homelessness, which both disproportionately affect Black residents and communities of color (Arenas et al., 2024).

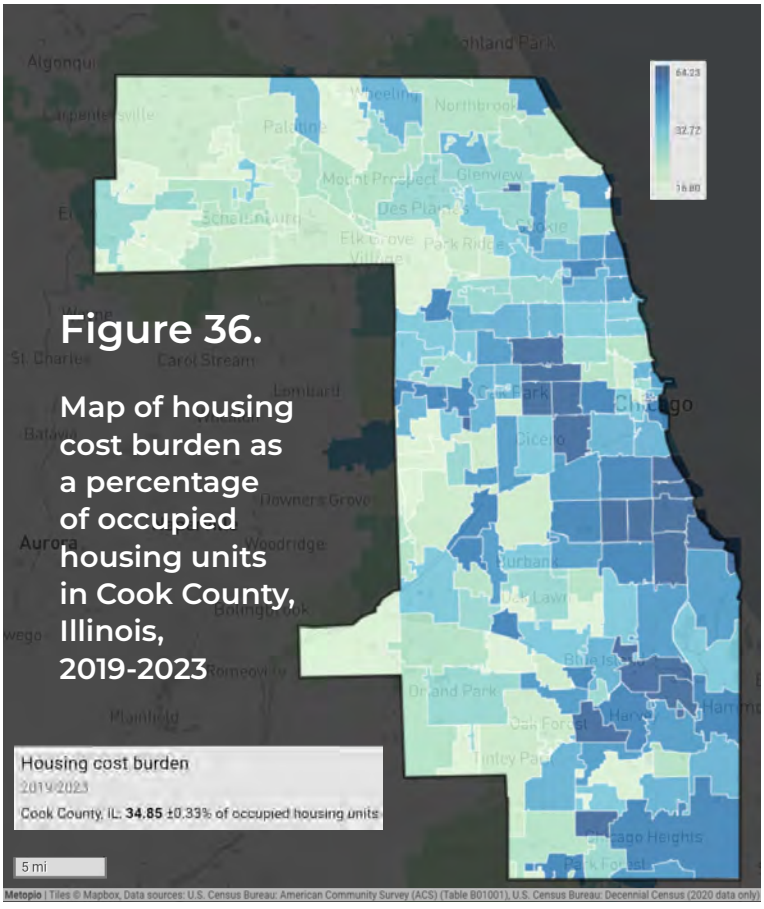


Figure 36.

Map of housing cost burden as a percentage of occupied housing units in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, American Community Survey, 2024)

> "I was eligible to be put on a section eight wait list, which I was told would be up to eight years. Eight years."
>
> — NAMI Metro Suburban focus group participant

Focus group participants commented that rent prices and the general cost of living have been rising dramatically post-pandemic, noting that while the rent has increased, people's salaries have not. Participants further described how property taxes and other economic pressures force middle-class families to leave their communities once children grow up. They acknowledged that living in Chicago is more affordable than some other U.S. metropolitan areas but expressed a need for more stable housing for people experiencing homelessness. In addition, high housing costs and gentrification are displacing long-term residents, disrupting social ties and community cohesion.

In focus groups, community members shared that immigrants have an especially difficult time identifying housing supports. They indicated that there is a disconnect between the availability of resources and awareness of those resources among the intended audience. Residents have witnessed the impacts of gentrification, primarily white people now living in apartment buildings where Black and Brown communities used to reside. Some focus group participants reported experiencing discrimination in the rental and home-buying markets, particularly among communities of color and low-income residents.

Consistency (housing stability)

Being without a stable home is harmful to one's health. Housing stability is influenced by many factors, such as:

- not being able to pay rent or make mortgage payments due to financial uncertainty
- being evicted, facing the threat of eviction
- the amount of household income spent on housing
- overcrowding (the number of people per room or unit)
- frequently moving
- doubling up
- living in short-term temporary housing (ex. hotel, motel, SRO or hostile)
- housing market volatility
- personal stressors
- experiencing homelessness (Nyamathi & Salem, 2021).

Housing instability can significantly affect a person's health throughout their lifespan. Caregivers of children who have experienced unstable housing or homelessness are more likely to report fair or poor health, maternal depressive symptoms, and household material hardships (Sandel et al., 2018). In addition, their children have higher rates of lifetime hospitalizations and fair or poor child health (Sandel et al., 2018). Youth and young adults that have experienced housing instability have an increased likelihood of experiencing multiple health concerns, including teen pregnancy, early drug use, and depression (Robert Wood Johnson Foundation, 2011). Homelessness also exacerbates existing health issues. Individuals without a comfortable, safe, supportive place to rest, heal, and recover after hospitalization may end up back in the hospital (National Healthcare for the Homeless Council, 2022).

Focus group participants discussed the impact of unaffordable and substandard housing on health, including issues like overcrowding, exposure to environmental hazards, and frequent relocations. Homelessness and the threat of eviction were cited as adding significant stress and instability to families; participants noted the reluctance to use shelters due to concerns over shared spaces and a lack of privacy, and while they appreciated the support, some raised concerns about other challenges within these settings, including safety and the emotional toll of instability. Additionally, focus group participants cited the lack of affordable housing as a root cause of homelessness, noting that many homeless individuals are in "survival mode," without access to stable housing or preventive healthcare. Long waiting lists for housing assistance programs like Section 8 vouchers were common, with limited availability compounding the issue.

The City of Chicago's Department of Family and Support Services (DFSS) and Department of Housing (DOH) have implemented some interventions to prevent residents from becoming homeless. From June 2021 to December 2023, the City of Chicago's Department of Housing (DOH) held the Emergency Rental Assistance Program (ERAP), providing rental assistance to 24,580 households for 18 months. Currently, the DOH has a pilot intervention, the Right-to-Counsel program, which provides free legal assistance to low-income residents facing eviction. So far, 85% of participants have avoided eviction (City of Chicago Department of Family and Support Services & City of Chicago Department of Housing, 2024).

Context (neighborhood opportunity)

The physical and social characteristics of where people live have a substantial impact on their health. Research has shown that the availability of healthcare services, public transportation, nutritious foods at nearby grocery stores, overall safety, walkability, spaces to exercise, and air quality are linked to improved health (Taylor, 2018). Consequently, what neighborhood you live in dramatically determines your life expectancy. Therefore, a big part of improving health and decreasing the life expectancy gap is improving neighborhoods for low-income individuals (Healthy Chicago 2025 Strategic Plan, n.d.).

Abandoned buildings and lots are associated with health and safety. Findings from one study suggest that city neighborhoods with high long-term vacancy rates are significantly associated with adult health problems, and efforts to reduce vacant properties should focus on units that have been vacant for the longest period of time (Immergluck & Wang, 2018). Remediated abandoned buildings and vacant lots have been associated with significantly decreased heart rates and reduced firearm violence (South et al., 2015). Focus group participants, especially those from the South and West Sides of Chicago, pointed out the prevalence of abandoned buildings, and lack of services within their neighborhood.

The structural racism of redlining and segregation also impact health and are linked to many adverse health outcomes (Taylor, 2018). Racial residential segregation is the physical separation of race groups into different residential areas, and in this country, the segregation was fueled by discriminatory housing and lending practices, such as redlining (Reddy et al., 2022). Redlining is the systematic implementation of discriminatory practices that denied mortgages in neighborhoods of color while ensuring mortgages in predominantly white neighborhoods; to this day, redlining has impacted access to wealth, community disinvestment, and ongoing segregation in neighborhoods (Lynch et al., 2021).

Internet access

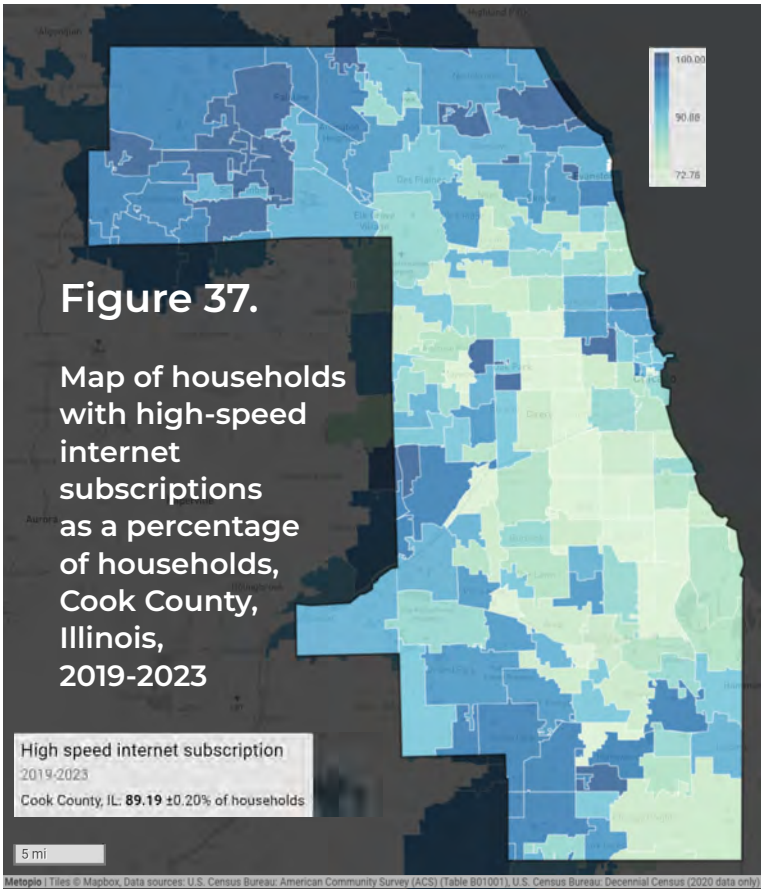
Access to the internet has become a significant contributor to an individual's health. The COVID-19 pandemic increased the use of several digital healthcare tools, such as telehealth appointments, portal-based patient communication, and more (Crock Bauerly et al., n.d.). Stable internet access is required to complete schoolwork that has been uploaded to digital platforms (ex. Canvas, Blackboard, Google Classroom). In Illinois, the percentage of Black/African American households (58%) and Hispanic/Latine households (63%) that have high-speed internet is less than the percentage of white households (71%). In the United States, only 63% of older adults aged 65-74 have high-speed internet (US Census Bureau, American Community Survey, 2024). Suburban communities have higher rates of high-speed internet subscriptions compared to communities within the city (Figure 37).

Focus group participants expressed that healthcare technology can be difficult to use. Many older adults had trouble making appointments online and thought it was much easier doing this through the phone. Some participants proposed that there should be an accessible resource to teach them on how to use digital tools. Others expressed that technology has helped them maintain a strong sense of community, older adults with mobility issues have mentioned that the use of online video conferencing and communications platforms have assisted them in successfully attending their online classes.

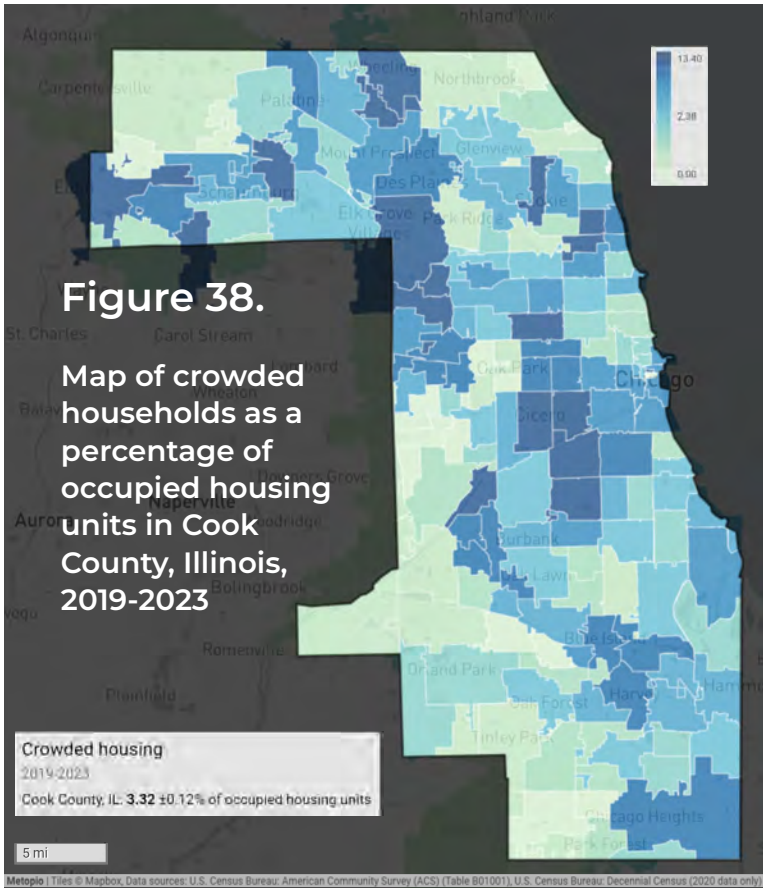
Conditions (housing quality and safety)

Housing quality and safety refer to the physical and social conditions inside a home or residence. Unfortunately, due to systemic racism and intentional segregation, low-income individuals and families are more likely to live in substandard housing with respect to building quality, safety, and function.

Poor housing conditions can also lead to health conditions, including respiratory infections, infectious diseases, and injuries such as asthma, allergies, lead poisoning, psychological distress, and cardiovascular disease (Jacobs, 2011; Krieger & Higgins, 2002; Sims et al., 2020). Poor and unstable housing conditions that affect health outcomes include air pollutants, second-hand smoke exposure, lead exposure, bad air, bad water quality, inadequate plumbing and sanitation, poor ventilation, carpeting, pest infestations, insufficient heating and cooling, lack of housing maintenance, and other aspects of housing that are structurally and functionally inadequate (Ahmad et al., 2020).



Source: (US Census Bureau, American Community Survey, 2024)



Source: (US Census Bureau, American Community Survey, 2024)

Air pollutants, specifically particulate matter and elemental carbon, are associated with cardiovascular disease and mortality (Mitchell et al., 2007; Sims et al., 2020). In addition, second-hand smoke exposure is highly prevalent among residents in multiunit housing and public housing, and secondhand tobacco smoke can migrate through shared ventilation systems, unsealed cracks, and door spaces, leading to adverse health outcomes (Sims et al., 2020). Lead exposure can lead to permanent brain and nervous system damage in children (World Health Organization, 2024b). Insufficient heating and cooling are associated with higher blood pressure and increased risk of cardiovascular events, particularly among older adults (Saeki et al., 2015). Some focus group participants from a West Side of Chicago neighborhood linked air pollution exposure to asthma rates in their communities.

Crowded housing and the need to utilize communal bathrooms have also been linked to adverse effects on one's health, as they interfere with good personal hygiene and effective physical distancing (Ahmad et al., 2020). Crowded housing has even been found to negatively impact a child's school achievement, behavior, and physical health (Solari & Mare, 2012). There are great disparities across the county in the level of crowded housing (Figure 38). Seven percent of Hispanic or Latino households and Asian households are considered crowded, compared to only 1.6% of non-Hispanic white households (US Census Bureau, 2024).

EDUCATION

Education is an important determinant of health because poverty, unemployment, and underemployment are lowest among those with higher levels of educational attainment. Focus group participants that lived in communities with good schools often highlighted them as one of the best things about their communities.

Early childhood care and education

The early years of life, from birth to age 8, are critical for brain development and lay the foundation for future success. High-quality early childhood care and education positively impact children's social-emotional well-being, educational achievement, health, and long-term socioeconomic outcomes (Centers for Disease Control and Prevention, 2025a; UNESCO, 2022). Early childhood care and education programs also can promote positive health behaviors such as healthy eating and physical activity, helping prevent childhood obesity and fostering lifelong healthy habits (Centers for Disease Control and Prevention, 2025a).

Access to early childhood care and education promotes equity, social justice, and sustainable development (UNESCO, 2022). Economically, investments in early education yield greater returns than later interventions (UNESCO, 2022). Studies demonstrate that early childhood care and education enhance school readiness and narrow gaps between privileged and marginalized children (Centers for Disease Control and Prevention, 2025a; UNESCO, 2022).

Focus group participants described childcare programs as prohibitively expensive. Participants highlighted insufficient financial aid or support for working parents balancing childcare and other expenses, highlighting a major gap in current systems. Some families rely on intergenerational support for childcare, but aging caregivers often struggle to meet the needs of their grandchildren, particularly in cases where grandparents face health or socioeconomic challenges.

Attendance

According to the Illinois State Board of Education, student attendance has been fairly stable: 93.9% in 2018, 92.5% in 2021, and 91.6% in 2024 (Illinois Report Card, 2024b). However, an American Institutes for Research report notes lower attendance rates in high poverty districts, lower achieving districts, and district schools who serve mostly students of color (Carminucci, et. al, 2021).

Attendance rates for Chicago Public Schools (CPS), where 76% of students are classified as low income, have been dropping since 2018; as of 2024, CPS attendance for all K-12 schools was 88.2% (Chicago Public Schools, 2024). In addition, chronic absenteeism, or missing more than a tenth of school days per year, is a large problem. In 2024, the rate of chronic absenteeism for CPS was 40.8% versus 26.3% for the state of Illinois (Figure 39). Rates of chronic absenteeism in CPS are particularly high among students with disabilities (45.3%), non-binary students (45.7%), students in foster care (47.1%), students experiencing homelessness (65.7%), and students with a parent or guardian in the military (66.7%) (Figure 39).

Figure 39.

Table of chronic absenteeism as a percentage of all students in Chicago Public Schools, 2024

	CHICAGO PUBLIC SCHOOLS	ILLINOIS
Total	40.8%	26.3%
Students with disabilities	45.3%	32.7%
English learners	41.5%	32.1%
Students experiencing homelessness	65.7%	54.6%
Low-income students	44.9%	36.3%
Students with a parent or guardian in the military	66.7%	20.3%
Youth in foster care	47.1%	38.0%
Non-binary students	45.7%	23.6%

Source: (Illinois Report Card, 2024a)

Graduation Rates

In the 2023-2024 academic year, Chicago Public Schools reported that its dropout rate is 9.0%, a 0.4% decrease. Its four-year graduation rate for the class of 2024 was 84.1% (Figure 40)(Chicago Public Schools, 2024). Illinois had a significantly lower dropout rate of 2.7% and a slightly higher graduation rate of 87.7% (Figure 40). Given that more than three-quarters (76%) of CPS students are classified as low income compared to slightly less than half of students throughout the state, (49.8%) low income (Illinois Report Card, 2024a), it shows that high school graduation rates tend to decrease as poverty rates increase (Figure 41).

Figure 40.

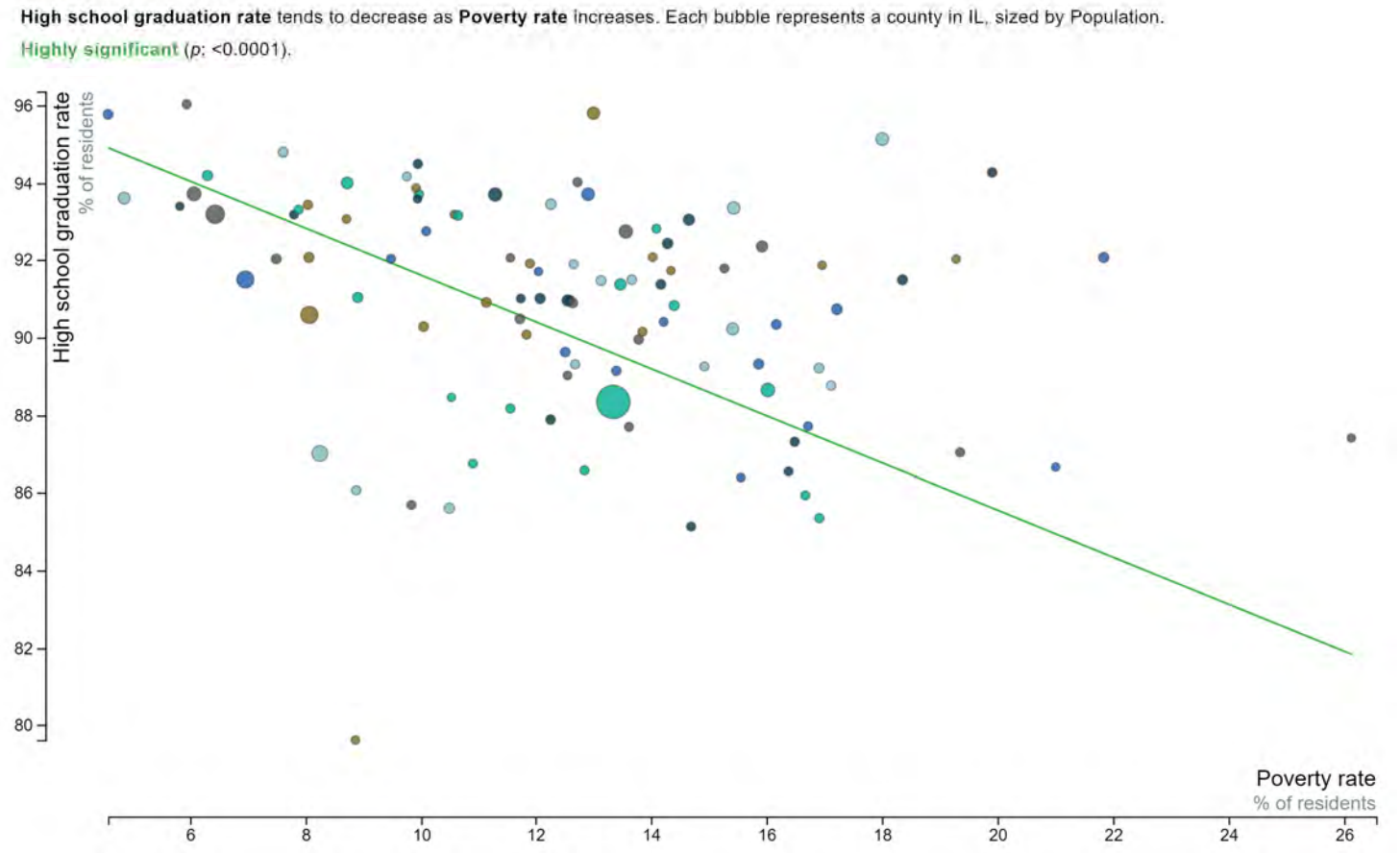
Table of dropout rate and graduation rate as a percentage of students in Chicago Public Schools, 2024

PERCENT OF STUDENTS IN 4-YEAR COHORT	CHICAGO PUBLIC SCHOOLS	ILLINOIS
Dropout rate	9.0%	2.7%
Graduation rate	84.1%	87.7%

Source: (Chicago Public Schools, 2024; Illinois Report Card, 2024a)

Figure 41.

Chart of correlation between low high school graduation rate and high poverty rate in Illinois counties, 2019-2023



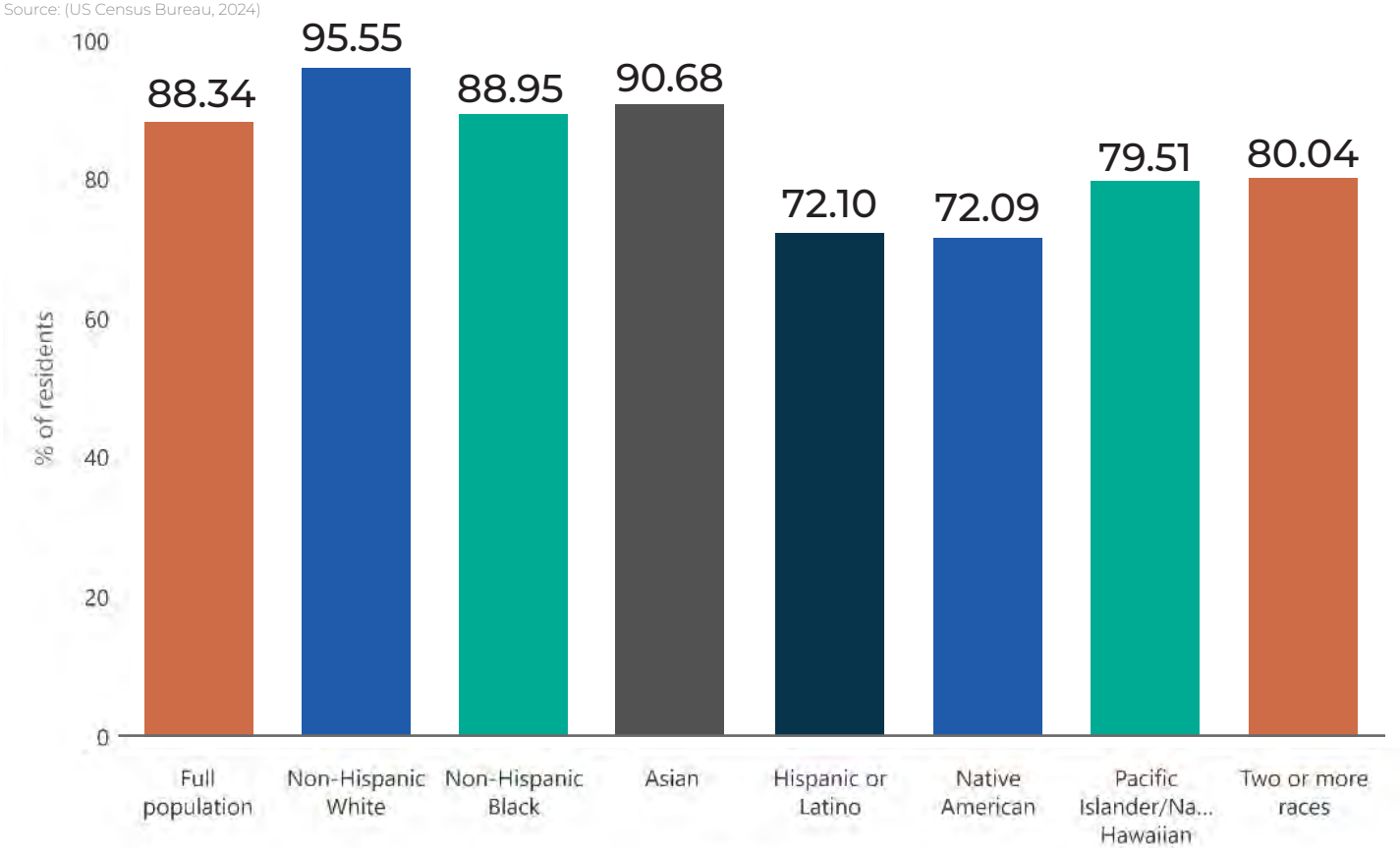
Created on Metopio: https://metop.io/i/gpcptdyj | This was determined to be a highly significant relationship via regression analysis, explaining 50.4% of the variation in the Y axis (R-squared). Source: (US Census Bureau, American Community Survey, 2024)

Economic hardship is linked to lower high school graduation rates and delayed college enrollment. High school graduation rates in Cook County are lowest for Hispanic or Latino and Native American students (72.1%) who are 20% less likely to graduate compared to non-Hispanic white students (Figure 42). However, graduation rates for Hispanic or Latino students have increased by about 10% over the last decade (US Census Bureau, 2024).

Figure 42.

Chart of high school graduation rate as a percentage of residents by race and ethnicity, Cook County, Illinois, 2019-2023

Source: (US Census Bureau, 2024)



School resourcing, funding, and programming

The Urban Institute highlights persistent school segregation tied to school rankings, and rankings influence disparities in staff quality, resources, programs, and student achievement (Monarrez & Chien, 2021). For instance, schools in predominantly Black/African American or Hispanic/Latine areas are more likely to have inexperienced or absentee teachers, which subsequently is factored into school rankings and result in these schools being more negatively labeled compared to those in more diverse communities, which furthers inequities (Monarrez & Chien, 2021).

Quality schools are one of the most critical components of a neighborhood. Due to racialized property value systems that assign higher values to housing in white neighborhoods, in the United States, many schools in low-income areas are underfunded because school funding relies heavily on local property taxes. Cook County residents had diverse responses when it came to the quality of schools in their neighborhood — in focus groups, some participants cited good schools as among the many assets in their community while others recounted the challenge of travelling long distances to attend a properly funded school because they did not have one in their own neighborhood and sought better educational opportunities for their children, which they saw as a direct consequences of inadequate local schools.

Focus group participants expressed dissatisfaction with the quality of education in some schools. Participants noted that key subjects like history, music, art, and home economics were no longer part of the curriculum. In addition, schools with limited wraparound services, such as counseling and extracurricular activities, were seen as failing to meet students' holistic needs. Concerns were raised about systemic criminalization of youth particularly in Black and Brown communities, and the school-to-prison pipeline leading to limited opportunities and increased vulnerability.

Educational opportunities and outside of school programs

Focus group participants emphasized programs that target young people, including educational workshops, extracurricular activities, and workforce development initiatives, as crucial for empowering the next generation and building a healthier future. A lack of after-school programs and recreational activities for children and teens was a frequent concern. Participants emphasized the need for safe spaces and structured programs to engage young people, including programs specifically for LGBTQIA+ youth.

Bullying

For 73% of Chicago parents, bullying is a large issue (Stanley Manne Children's Research Institute, 2023). Over the years, cyberbullying has also become a cause for concern for students and parents. Focus group participants linked declining mental health in youth to bullying and excessive social media use. In a 2021 survey by the Cyberbullying Research Center, 23% of students reported having been cyberbullied in the last month. Thirty five percent of transgender students reported having been cyberbullied compared to 24% of female and 22% of male students (Hinduja, 2021).

Social and economic factors strongly relate to how big of a concern bullying is for parents. Non-Hispanic Black parents (78%), parents without a high school degree (80%), and parents with household incomes under the federal poverty line (89%) were most concerned about bullying in schools (Stanley Manne Children's Research Institute, 2023).

COVID-19

COVID-19 disrupted education across all age groups, forcing students to adapt to remote, hybrid, or in-person learning transitions. Fully remote schools reported reduced student interaction. Many preschools and daycares closed, raising concerns about learning gaps, particularly for children of color, low-income families, children with disabilities, and English learners (Tate & Warschauer, 2022). Socioeconomic inequities that already affect educational performance among children of color were exacerbated by pandemic-related delays in early education participation, potentially impacting long-term academic success (Tate & Warschauer, 2022).

FOOD ACCESS AND FOOD INSECURITY

Food access

Food access is defined in terms of accessibility, affordability, and food sovereignty. The ability to access and afford food is often intimately tied to systemic racism, and social and structural determinants of health that influence the conditions in which individuals, families, and their communities live (Centers for Disease Control and Prevention, 2024d, 2024j; Odoms-Young et al., 2024).

Many communities in Cook County lack affordable access to healthy food. Focus group participants highlighted the prevalence of food deserts, stating that families often rely on processed, low-cost foods that contribute to health issues like obesity and malnutrition. Five percent of community input survey respondents identified hunger as a top health issue in their community. In addition, 19% of respondents said improving community health would require improved food resources. Research indicates that communities with better access to healthy foods and limited access to convenience stores have healthier diets and lower rates of obesity, diabetes, heart disease, and some types of cancers (Odoms-Young et al., 2024).

Low-income communities of color are less likely to have access to supermarkets and healthy foods, and tend to have a higher density of fast-food restaurants and other sources of unhealthy food such as convenience stores, leading to areas of food apartheid where it is difficult to buy affordable or good-quality food (Odoms-Young et al., 2024; Sevilla, 2021). Historically redlined Black and Brown

communities that have been impacted by decades of disinvestment by developers have few grocery stores and experience challenges with affordability due to being excluded from wealth-building opportunities (Odoms-Young et al., 2024; Shaker et al., 2023). The percentage of people in Cook County with low food access is 39% which is lower than the rates for Illinois and the United States (Figure 43). The proportion of people living in areas of low food access is highest in Suburban Cook County communities (Figure 44).

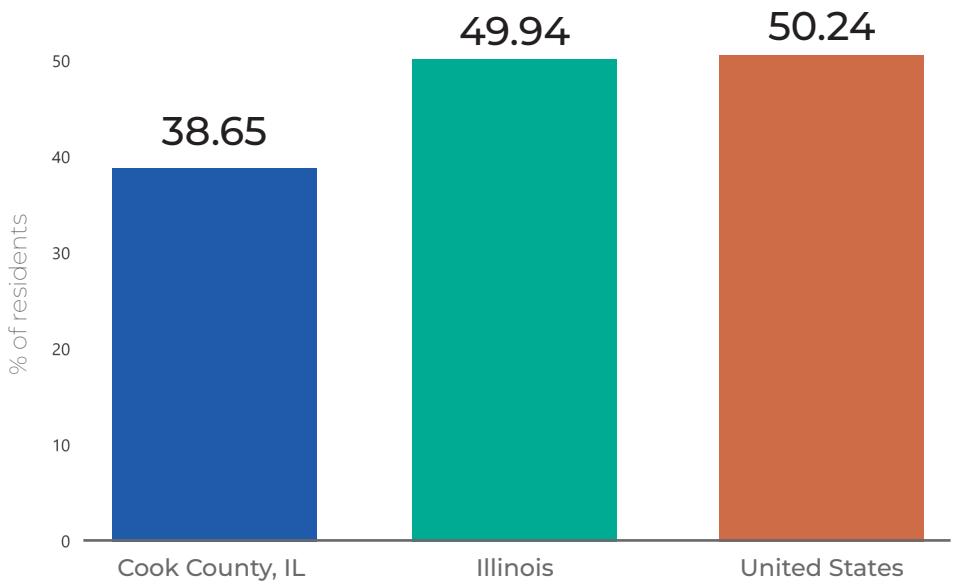


Figure 43.

Chart of low food access as a percentage of residents in Cook County, Illinois, 2019

Source: (United States Department of Agriculture, 2019)

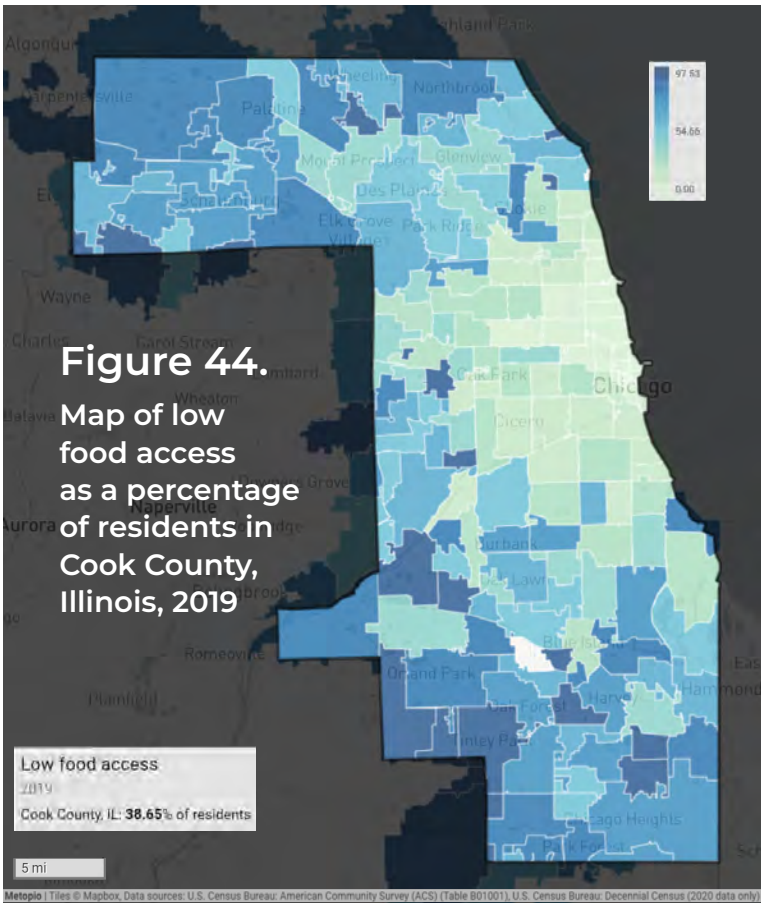


Figure 44.

Map of low food access as a percentage of residents in Cook County, Illinois, 2019

Source: (United States Department of Agriculture, 2019)

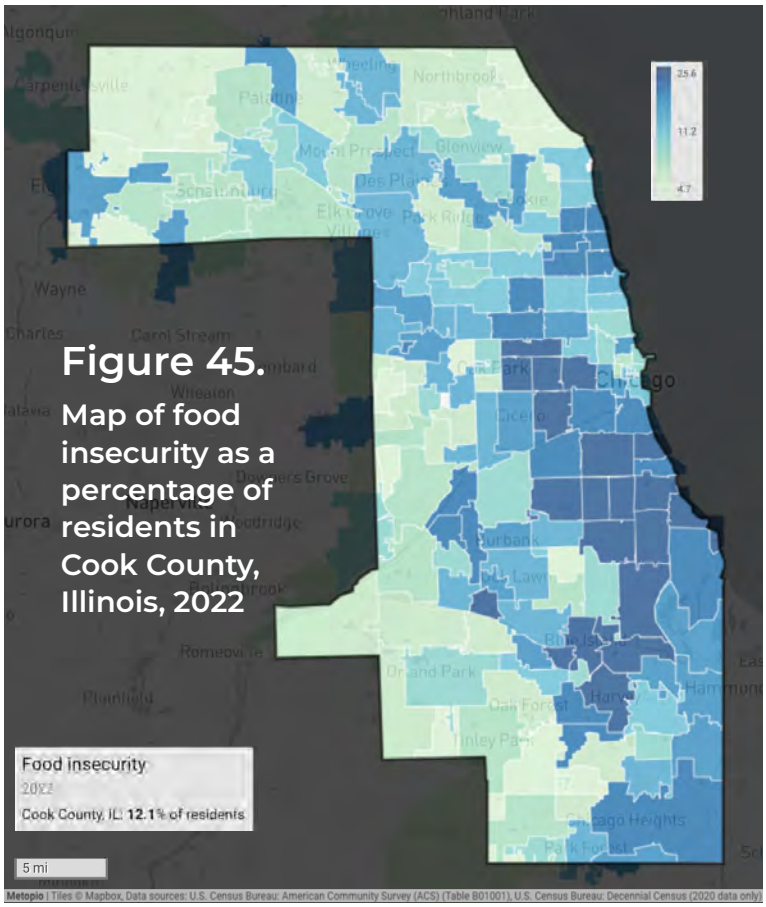


Figure 45.

Map of food insecurity as a percentage of residents in Cook County, Illinois, 2022

Source: (Feeding America, 2022)

Food insecurity

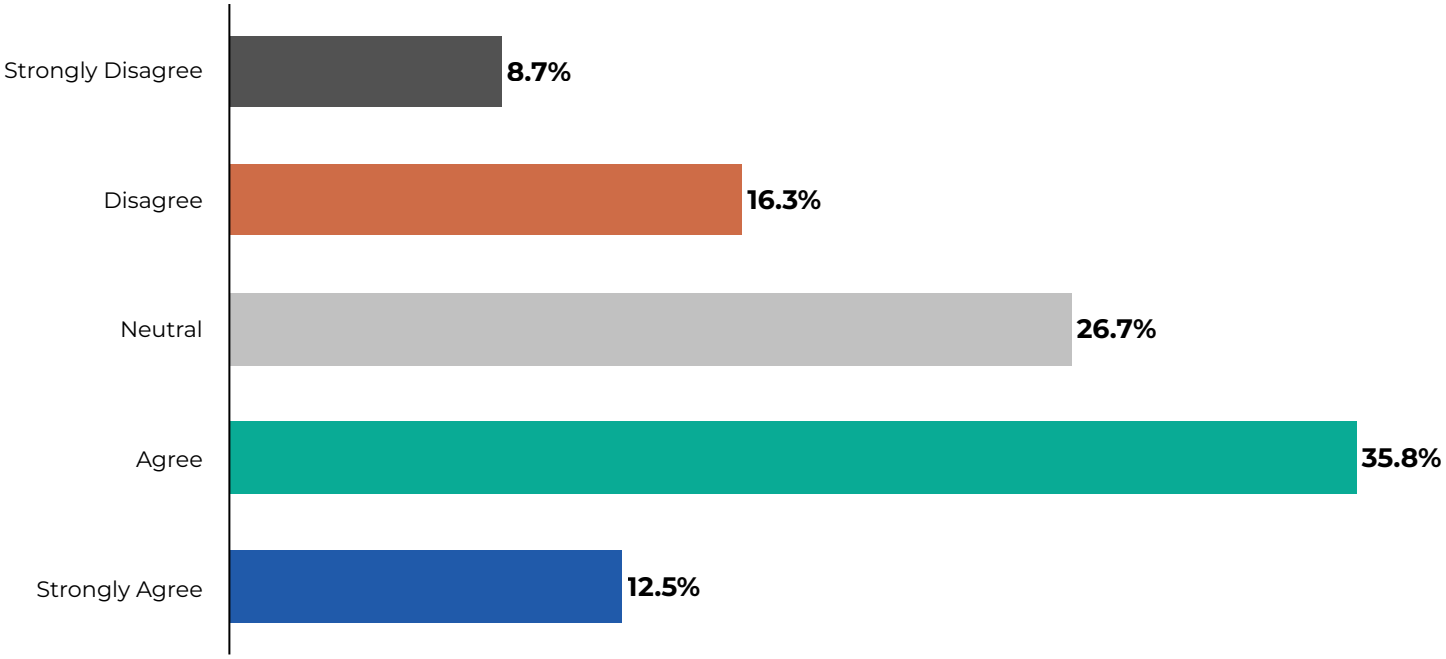
Food insecurity is a systemic issue that occurs when people are unable to access the food they need to live their fullest lives (Feeding America, 2024). There are several root causes of food insecurity including poverty, unemployment, lack of affordable housing, chronic health conditions, racism, and discrimination (Feeding America, 2024; Odoms-Young et al., 2024). Food insecurity can harm health and well-being, increasing the risk of malnutrition, chronic conditions, stress, depression, and anxiety (Feeding America, 2024; Odoms-Young et al., 2024). It can also lead to social isolation, stigma, and reduced productivity in work and school settings due to low energy and illness (Feeding America, 2024). In addition to Black and Brown communities, other populations including people living with chronic health conditions, people living with disabilities, families with children, transwomen of color, LGBTQIA+ people, indigenous peoples, and immigrants often experience a higher burden of food insecurity (Feeding America, 2024; Odoms-Young et al., 2024; Russomanno et al., 2019; Sevilla, 2021). Like most social and structural determinants of health, there are geographic inequities in food insecurity in Cook County (Figure 45).

Community input survey respondents were asked to agree or disagree with the statement "I am satisfied with the availability of fresh and healthy foods in my community," and 48% agreed or strongly agreed (Figure 46).

Figure 46.

Survey Responses – Agreement with the statement:

I am satisfied with the availability of fresh and healthy foods in my community. (n=1847)



Nutrition programs and emergency food systems

The Supplemental Nutrition Assistance Program (SNAP, also known as food stamps), local food pantries, summer meal programs, after-school programs, shelters, and food banks provide important assistance to low-income individuals and families that struggle to access adequate nutrition. The percentage of households receiving SNAP benefits in Cook County is 15%, which is higher than state and national averages (Figure 47). The western and southern regions of the County have the highest proportions of households receiving SNAP benefits (Figure 48).

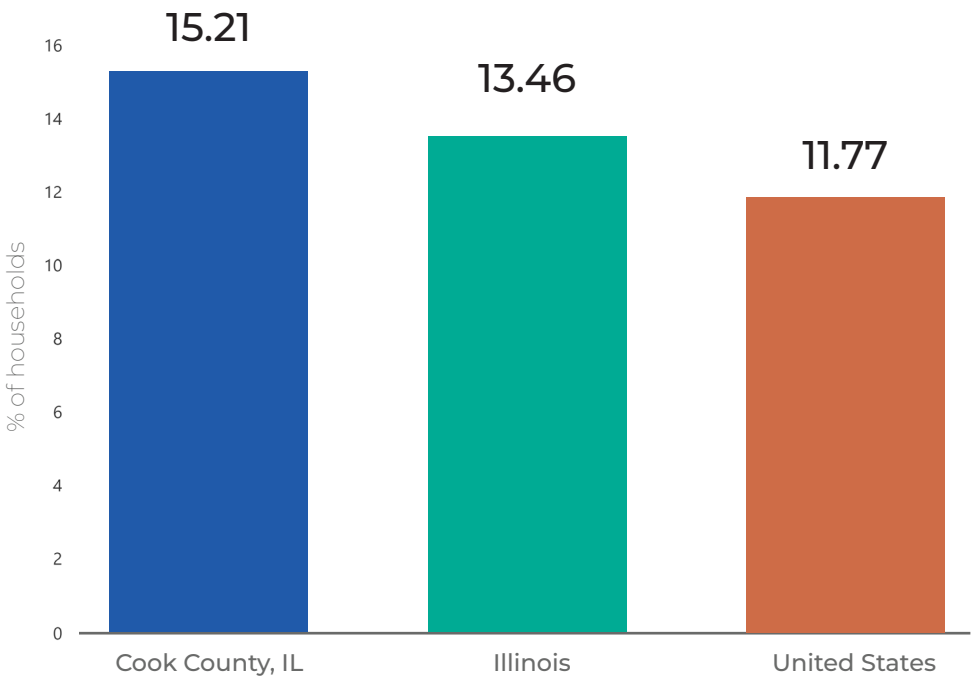


Figure 47.

Chart of households receiving SNAP benefits as a percentage of all households in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, 2024)

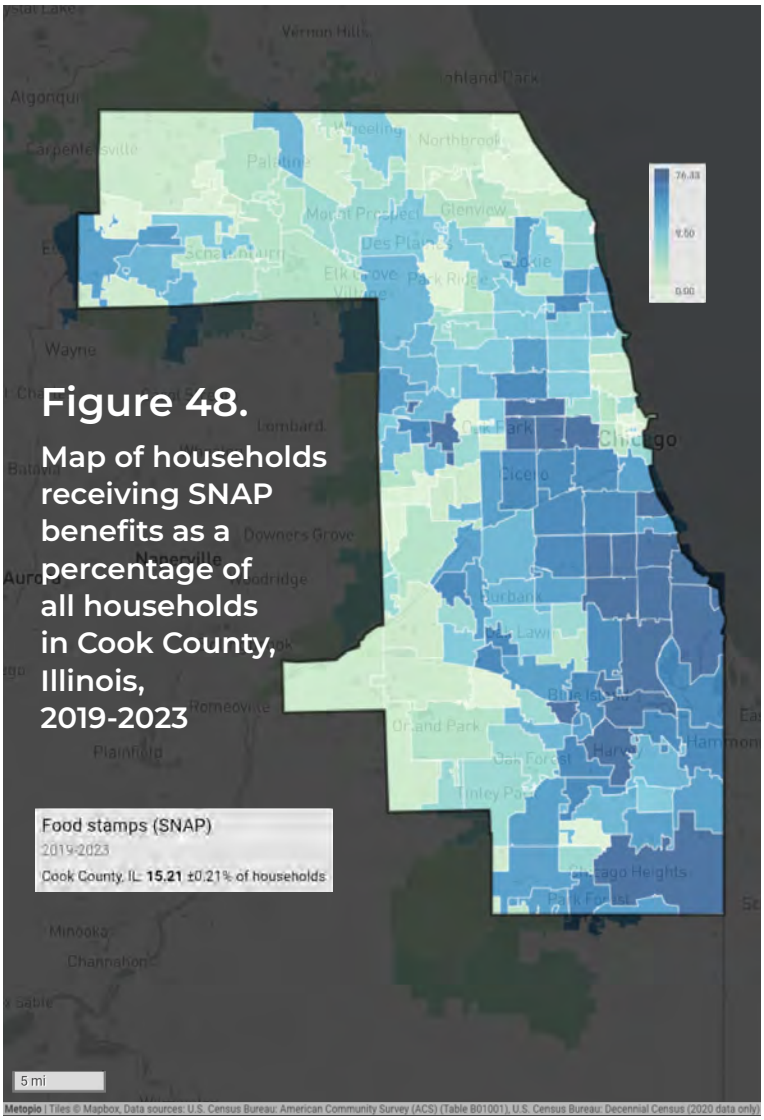


Figure 48.

Map of households receiving SNAP benefits as a percentage of all households in Cook County, Illinois, 2019-2023

Source: (United States Department of Agriculture, 2019)

The Women, Infants, and Children (WIC) program helps address food and nutrition insecurity for low-income pregnant and postpartum individuals, infants, and children under 5. Unlike SNAP, WIC includes nutrition education, provides supplemental nutritious foods, and offers screenings and referrals to other social services.

SNAP and WIC benefits across Cook County are often underutilized by eligible individuals due to several barriers. Over 50% of Cook County households living in poverty do not receive SNAP (Figure 49). Some of barriers to participation include time, mobility, technology, stigma, difficulty meeting requirements for participation, and misinformation about who qualifies.

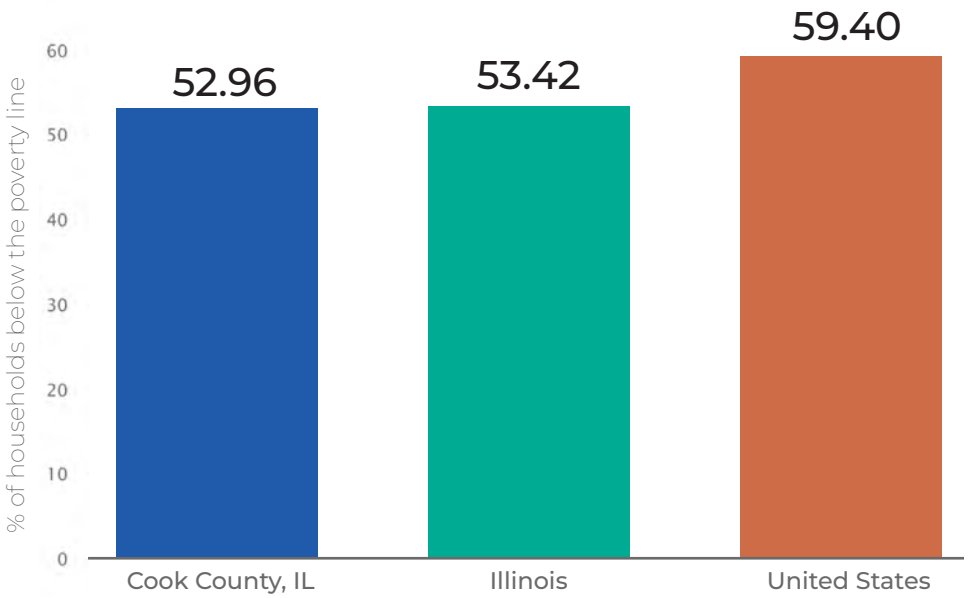


Figure 49.

Chart of households in poverty that do not receive SNAP benefits as a percentage of households in poverty in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, 2024)

Affording nutritious food is a challenge for many families. In 2023, SNAP benefits didn't cover the average cost of a meal in over 99% of U.S. counties (Waxman et al., 2023). Immigrant communities are particularly affected, often unaware of their eligibility or hesitant to apply due to fear that has been worsened under the Trump Administration due to changes to the Public Charge Rule (D. Gonzalez & Bernstein, 2023). This "chilling effect" has led as many as 1 in 4 immigrant families to forgo benefits, worsening food insecurity (D. Gonzalez & Bernstein, 2023). Focus group participants described insufficiencies and reductions in programs like SNAP benefits and other financial assistance as exacerbating economic hardships.

Free and reduced-price school lunches are vital because they ensure students have access to nutritious meals, which directly impact their health, learning, and overall well-being. Access to school lunch programs has been shown to improve academic performance, reduce hunger and food insecurity, promote healthier development, provide economic relief for families, and promote equity for students and their communities (Blossom, 2023; Feeding America, 2012)

Summer meal programs also play an important role in food access for low-income children and their families during the months when schools are closed and access to free or reduced-price meal programs is decreased (Boone & FitzSimons, 2024). In Cook County, summer meal sites are widespread but most are concentrated in Chicago within communities that have high rates of child poverty.

COMMUNITY SAFETY

Perceptions of neighborhood safety

The perceived neighborhood safety rate is the percentage of adults who report that they feel safe in their neighborhood "all of the time" or "most of the time" (Cook County Department of Public Health, 2023). The overall perceived neighborhood safety rate in Suburban Cook County is 88.7% (Cook County Department of Public Health, 2023). In Chicago, the average perceived rate is 59.6%, varying widely by community area. The highest rates of perceived neighborhood safety are on the North Side, while the lowest rates are on the West and South Sides. The rate in Forest Glen (94.6%), the community area with the highest rate, is 72% higher than the rate of Riverdale (22.9%), which has the lowest rate (Figure 50).

Community members expressed mixed opinions on the safety of their communities. Forty-nine percent of community input survey respondents reported they feel their community is a safe place to live (Figure 51). In addition, several focus group participants expressed pride in living in neighborhoods they perceive as safe, peaceful, and welcoming. They emphasized a strong sense of security in their immediate surroundings, citing the presence of caring neighbors and well-maintained environments as contributing factors. Other key themes included community safety initiatives and well-maintained infrastructure.

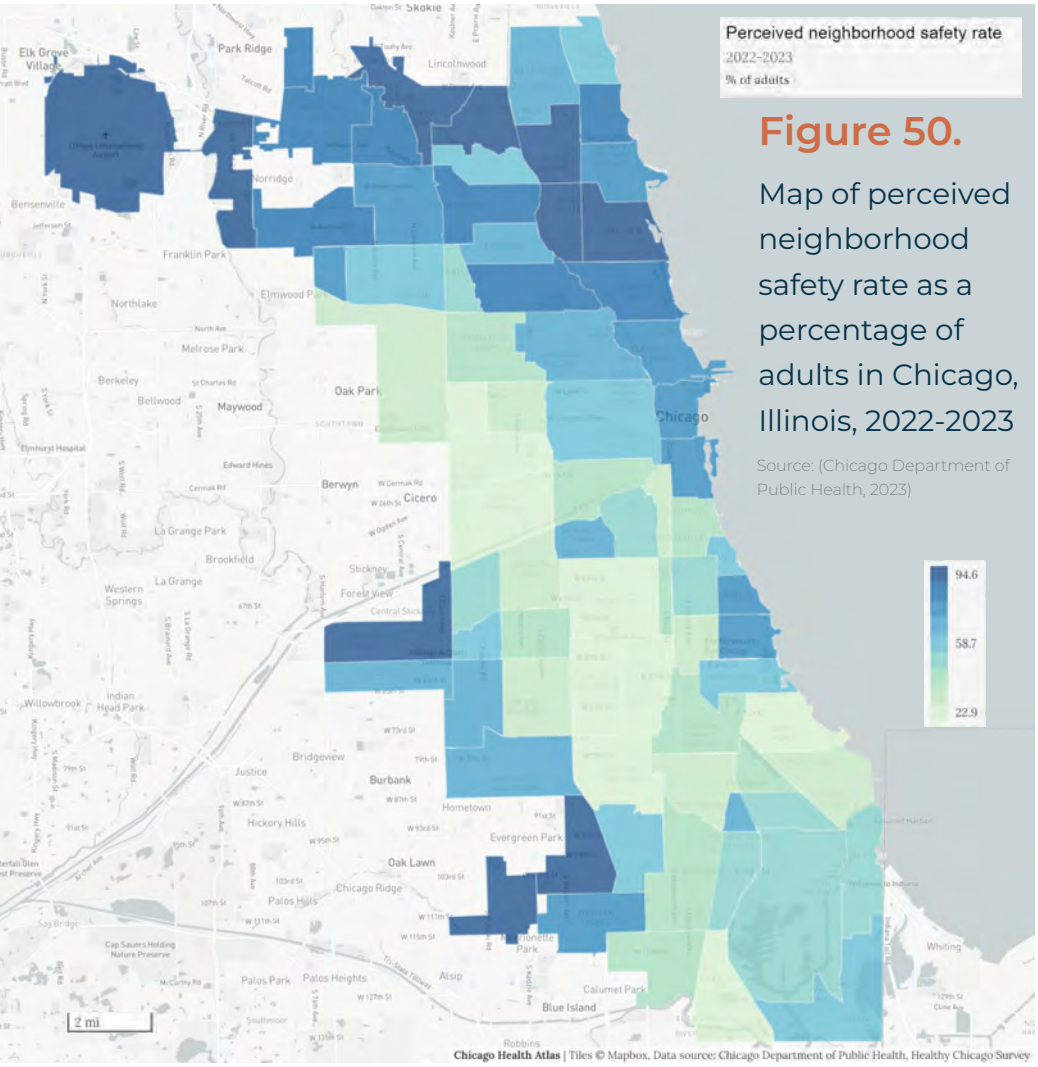


Figure 50.

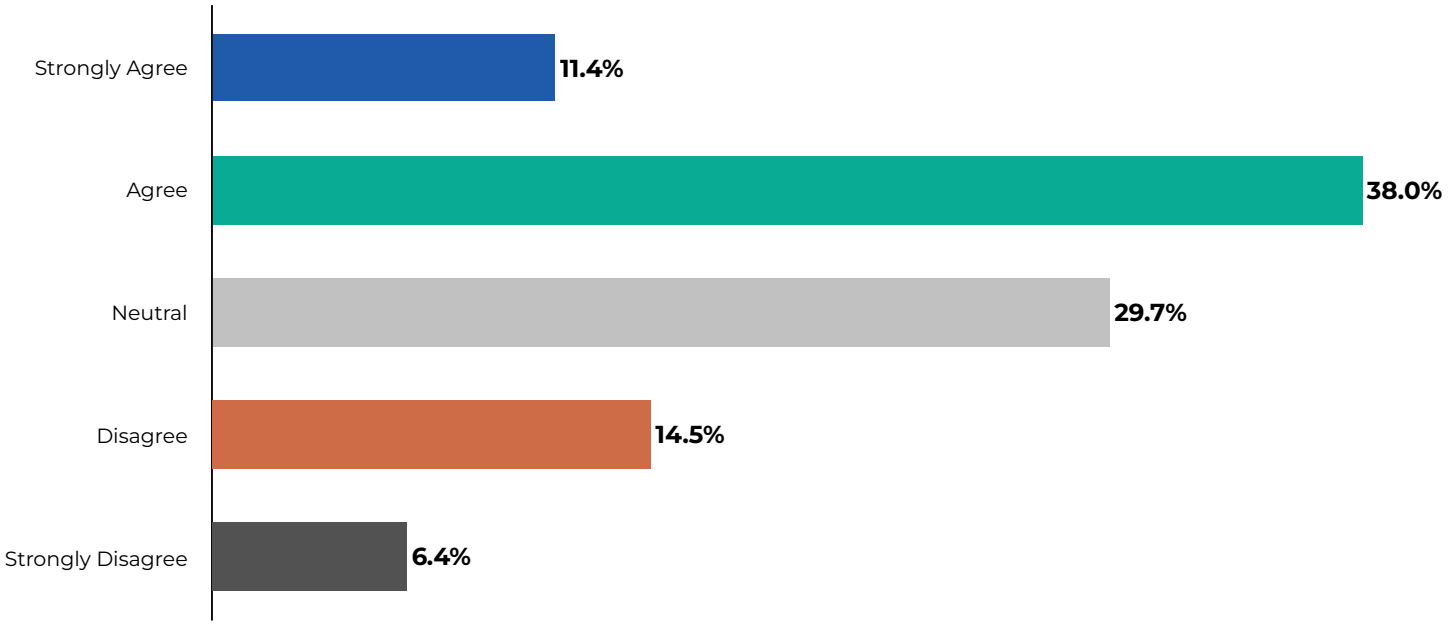
Map of perceived neighborhood safety rate as a percentage of adults in Chicago, Illinois, 2022-2023

Source: (Chicago Department of Public Health, 2023)

> "It's peaceful around here, mostly quiet and good neighbors"
>
> — NAMI Metro Suburban focus group participant

Figure 51.

Survey Responses – Agreement with the statement:
My community is a safe place to live. (n=1847)



Barriers to safe communities

The root causes of community violence are complex, driven by factors such as poverty, education inequities, limited access to health services, mass incarceration, differential policing, and generational trauma. These issues are often concentrated in economically disadvantaged communities of color, particularly in Cook County, where structural barriers like segregation and housing discrimination have deepened poverty (Fredrick, 2018).

Exposure to violence significantly impacts physical and mental health, with childhood exposure linked to trauma, toxic stress, and poor health outcomes throughout life (Centers for Disease Control and Prevention, 2024b). Additionally, violence exacerbates socioeconomic disparities, further challenging community well-being and equity (Centers for Disease Control and Prevention, 2024b; Fredrick, 2018).

Across the United States reports of interpersonal violence, including gun violence, child abuse, and intimate partner violence, increased during the COVID-19 pandemic (Smith-Clapham et al., 2023). In Illinois, there has been an uptick in violent crime overall since before the pandemic. In July 2019, the rate of reports of violent crime per 100,000 people was 44.8 and by July 2023 it had more than tripled to 159.0 (U.S. Federal Bureau of Investigation, 2022). During that same period, the rate of reported hate crimes per 100,000 people in Illinois increased by 900% (U.S. Federal Bureau of Investigation, 2022). These trends highlight the importance of continued violence reduction work including in areas such as research and funding, education in schools, bias in public health reporting, and systemic policy change (Findling et al., 2022).

Assessing violent crime on the local level is challenging due to inconsistent reporting standards across police jurisdictions. In Suburban Cook County, comparisons are difficult due to fragmented data collection policies across several law enforcement agencies. However, in Chicago, violent crime data can be analyzed by race, ethnicity, and geography. Crime rates vary significantly, with the highest concentrations on the South and West Sides of the city, where all of 10 of the areas with the highest incidence are located, compared to only four of the ten lowest-incidence areas (Figure 52).

Figure 52.

Table of Chicago community areas with the lowest and highest incidence of violent crime, 2023

CHICAGO COMMUNITY AREA	VIOLENT CRIME (COUNT)	REGION
Edison Park	11	North
Mount Greenwood	26	South
Forest Glen	27	North
Montclare	35	North
Burnside	39	South
O'Hare	40	North
Beverly	59	South
Norwood Park	59	North
Hegewisch	65	South
North Park	71	North
West Town	803	West
Englewood	806	South
Roseland	809	South
Auburn Gresham	826	South
Chatham	912	South
Greater Grand Crossing	928	South
Near West Side	1,035	West
North Lawndale	1,065	West
South Shore	1,200	South
Austin	1,899	West

Source: (Chicago Police Department, 2025)

In responding to the community input survey, violent crime ranked sixth overall in community members top health concerns (18% of respondents) while property crime ranked eighth (15% of respondents) (Figure 53).

Figure 53.

Table of community input survey respondents who rated community safety concerns among the top three biggest health issues in their community

HEALTH ISSUE	PERCENT
Adult mental health	26.3%
Substance-use	22.0%
Homelessness and housing instability	18.1%
Violent crime	17.6%
Property crime	15.3%
Child and adolescent mental health	15.2%
Racism and other discrimination	9.3%
Domestic violence	7.6%
Motor vehicle crash injuries	7.2%
Police brutality	4.2%
Child abuse	2.7%
Preventable injuries	1.7%

How focus group participants felt about the safety of their communities varied. The discussions underscored significant concerns about community safety and its impact on health and well-being. Gun violence, gang activity, substance use, homelessness, and domestic violence were mentioned as pervasive threats in many neighborhoods. They discussed how these problems were exacerbated by poor lighting and infrastructure, a lack of safe transportation options, unsafe parks and recreation areas, and strained relationships between law enforcement and communities. Exposure to violence was linked to trauma, stress, and mental health challenges, particularly among children and adolescents. Participants expressed that the fear of violence limits outdoor activities, social interactions, and engagement in community life.

> “I’m scared to come home at night, like I don’t like going out at night because I want to be home by 8 o’clock because then it’s scary just walking simply from your car to your house, especially if your street is very quiet. And then with all the carjacking that’s also been happening around my neighborhood, yeah, it’s just really scary and all the gangs.”
>
> — UI Health CHAMPIONS focus group participant

Interpersonal violence

Across the United States reports of interpersonal violence, including gun violence, child abuse, and intimate partner violence, increased during the COVID-19 pandemic (Smith-Clapham et al., 2023), and the COVID-19 pandemic disproportionately affected Black and Brown communities. From 2019-2021, the rate of interpersonal injury-related hospitalizations per 100,000 individuals in Suburban Cook County rose for non-Hispanic Black and Hispanic or Latino populations but declined for non-Hispanic whites. In 2022, overall rates declined, but the rate for Non-Hispanic Black individuals (353) was still more than six times that of Non-Hispanic whites (55) (Figure 54).

Figure 54.

Table of interpersonal injury hospitalization rate per 100,000 individuals by race and ethnicity in Suburban Cook County, Illinois, 2019-2022

	2019	2020	2021	2022
Overall	347	384	390	353
Non-Hispanic White	79	59	54	55
Non-Hispanic Black	183	226	222	196
Hispanic or Latino	49	58	86	68
Non-Hispanic Asian	5	10	4	4

Source: (Cook County Department of Public Health, 2024)

Like other types of community violence, in the United States, firearm-related mortality and homicide mortality disproportionately impact communities of color, driven by factors like poverty, disinvestment, low home ownership rates, and limited neighborhood resources. Cook County’s homicide- and firearm-related mortality rates exceed state and national averages (Centers for Disease Control and Prevention, 2024m). In Chicago and Suburban Cook County, disparities are stark: in Chicago, homicide mortality rates for Non-Hispanic Black residents are 28 times higher than for non-Hispanic whites, and 20 times higher in Suburban Cook County (Figure 55). Disparities in firearm-related mortality are even more stark, the rate for Non-Hispanic Black residents is 45 times higher than non-Hispanic whites in Chicago and seven times higher in Suburban Cook County (Figure 56).

Figure 55.

Table of homicide morality rate per 100,000 population in Chicago and Suburban Cook County, Illinois, 2022

	CHICAGO RATE PER 100,000 POPULATION	SUBURBAN COOK COUNTY RATE PER 100,000 POPULATION
Overall	22.4	9.7
Non-Hispanic White	2.4	2.1
Non-Hispanic Black	68.8	41.8
Asian or Pacific Islander	3.7	0.8
Hispanic or Latino	13.1	6.2

Source: (Illinois Department of Public Health, 2024b)

Figure 56.

Table of firearm-related mortality rate per 100,000 population for Chicago and Suburban Cook County, Illinois, 2022

	CHICAGO FIREARM-RELATED HOMICIDE MORTALITY RATE PER 100,000 POPULATION	SUBURBAN COOK COUNTY FIREARM-RELATED MORTALITY RATE PER 100,000 POPULATION
Overall	20.0	13.3
Non-Hispanic white	1.4	6.8
Non-Hispanic Black	62.9	47.5
Asian or Pacific Islander	3.2	0.3
Hispanic or Latino	11.1	7.2

Source: (Illinois Department of Public Health, 2024b)

Property crime

Like violent crime, property crime data comparisons in Suburban Cook County are limited. Within Chicago, the disparities mimic violent crime rates, with the highest rates concentrated on the West and South Sides (Figure 57). Overall, Chicago's property crime rate per 100,000 residents (3484.8) is almost double that of Illinois (1818.6) (Chicago Police Department, 2024; U.S. Federal Bureau of Investigation, 2022).

Falls and unintentional injuries

In 2022, the rate of emergency department visits for unintentional injuries was 7970.3 for every 100,000 people in the United States (Centers for Disease Control and Prevention, 2023b). However, different groups are more vulnerable than others; older adults are particularly vulnerable to injury or death from falling due to disability, balance problems, poor vision, or dementia (Centers for Disease Control and Prevention, 2023b).

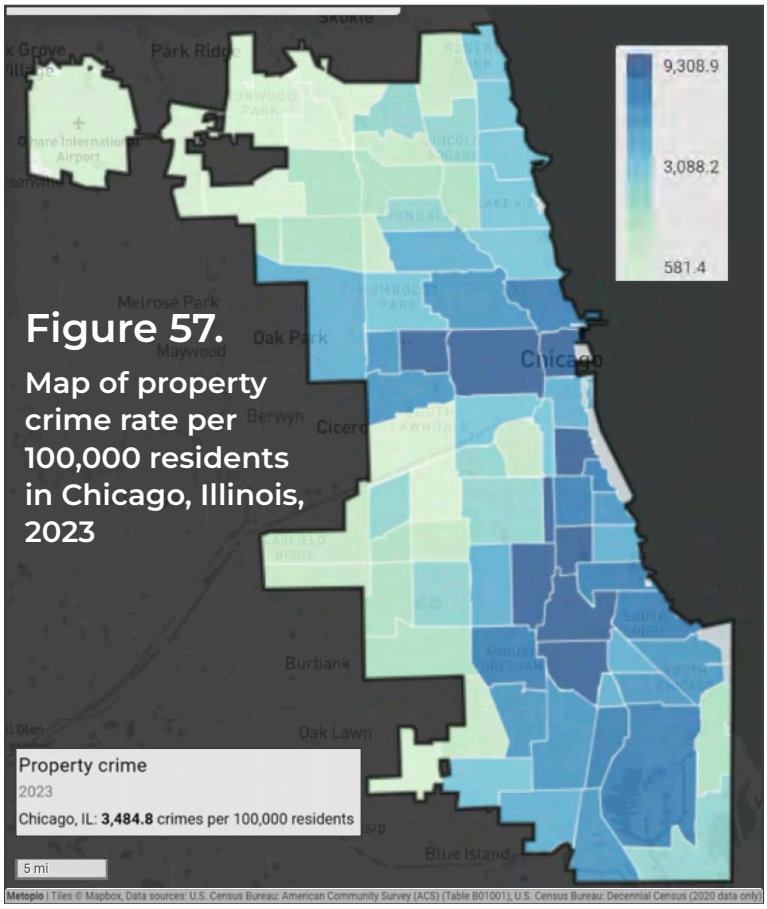


Figure 57.

Map of property crime rate per 100,000 residents in Chicago, Illinois, 2023

Source: (Chicago Police Department, 2023)

> "I also see for the young kids in our community, there's no safe space for them to go. They're in the streets. And they're like, in front of their houses. There's no playgrounds. There's no parks that are clean for them to go to."
>
> — NAMI Metro Suburban focus group participant

In 2022, the mortality rate for falls among older adults was 43.7 per 100,000 individuals in Cook County, 57.1 in Illinois, and 70.8 nationwide (Figure 58). Drowning is the number one cause of death for children ages one to four (Centers for Disease Control and Prevention, 2024g). Due to historical policies of segregation and oppression, Black and Brown communities are also disproportionately affected. For people younger than age 30, drowning rates for Black individuals are 1.5 times higher than whites and American Indian and Alaskan Native individuals are 2 times higher than whites (Centers for Disease Control and Prevention, 2024g).

Figure 58.

Table of unintentional injury rates in Cook County, Illinois, 2020-2022

	COOK COUNTY	ILLINOIS	UNITED STATES
Unintentional injury-related mortality rate per 100,000 individuals (2022)	67.9	57.2	66.0
Fall mortality rate per 100,000 individuals (2022)	8.7	9.0	11.2
Drowning mortality rate per 100,000 individuals (2022)	0.9	0.9	1.3
Percent of older adults who reported falling in the last 12 months (2020)	-	19.9%	27.6%
Older adult fall mortality rate per 100,000 individuals (2022)	43.7	57.1	70.8

Source: (Centers for Disease Control and Prevention, 2024o; Kakara et al., 2023)

Effects from a lack of community safety

Focus group participants discussed many negative outcomes caused by a lack of safety. Businesses avoid high-crime areas, limiting economic opportunities and perpetuating cycles of poverty and unsafe conditions. Public spaces dominated by individuals using drugs or drinking alcohol create a sense of unease and deprive communities of outdoor recreation spaces.

Children and teenagers were highlighted as particularly vulnerable to violence and unsafe environments. Concerns were raised about the lack of safety in and around schools, including bullying and school-based violence. Lack of safe recreational spaces for youth was noted as a contributing factor to their involvement in unsafe behaviors, such as gang activity and substance use.

Solutions

Respondents to the community input survey identified several health needs related to community safety as being a top priority. Activities for teens and youth was the top ranked health need at 26%, and safety and low crime was ranked fourth at 22% (Figure 59).

Figure 59.

Table of community survey responses of top health needs related to community safety (n=1782)

HEALTH NEED	PERCENT
Activities for teens and youth	26.2%
Safety and low crime	21.8%
Safe and affordable housing	19.7%
Walkable neighborhoods	10.8%
Welcoming neighbors and connections to community	9.9%
Clean air	9.3%
Safe water	6.7%
Parks and recreational spaces	6.1%
Easy access to public transportation	5.6%

Focus group participants discussed a vision for communities free from violence, with an increase in mutual respect among community members. Participants see violence prevention programs and community policing as critical steps toward fostering trust and security.

Focus group participants discussed several recommendations for programs targeting violence reduction. Collaborative efforts between health departments, law enforcement, and community organizations were seen as vital for addressing root causes of violence.

Figure 60.

Table of community suggested solutions for community safety issues

THEME	SUMMARY
Violence reduction	Fund hospital-based violence intervention programs to support victims and reduce repeat incidents.
Safe spaces	Participants recommended developing community centers and safe havens where residents, particularly youth, can gather in supportive and structured environments. Ensure these spaces provide recreational activities, educational resources, and access to counseling.
Conflict resolution	Establish programs that teach conflict resolution skills and provide mediation services to de-escalate tensions before they escalate into violence.
Address domestic and interpersonal violence	Expand shelters, counseling services, and legal aid for victims of domestic violence and abuse. Introduce programs in schools and community settings that teach skills for building healthy, respectful relationships.
Improve infrastructure	Invest in better street lighting, clean public spaces, and maintain infrastructure to deter criminal activity. Enhance the safety of public transportation systems to protect commuters, especially in vulnerable neighborhoods. Use urban planning strategies to design neighborhoods that discourage crime.
Community policing models	Encourage law enforcement agencies to adopt community policing strategies, where officers build relationships with residents and work collaboratively to address safety concerns. Empower community members to lead violence prevention efforts, leveraging local knowledge and trust.
De-escalation training	Advocate for mandatory de-escalation and cultural competency training for police officers to reduce incidents of excessive force.
Address root causes	• **Economic empowerment:** Promote workforce development programs, job creation, and training opportunities to address unemployment and poverty, which are often linked to violence. • **Educational opportunities:** Increase access to quality education and after-school programs to keep youth engaged and reduce their involvement in risky behaviors • **Mental health and trauma support:** Offer accessible mental health services to address trauma stemming from exposure to violence, fostering healing and resilience within communities.

ENVIRONMENT

The environment is the sum of all living and non-living elements and their effects on human life. Environmental health involves preventing illness and injury and promoting well-being within communities by identifying and reducing exposure to harmful physical, chemical, and biological elements in the air, water, soil, and other environments.

Like other social and structural determinants of health, safe and hazard-free environments are not equally distributed across Cook County. Low-income communities, communities of color, and

communities on the south and west sides of the county have the highest exposure to environmental hazards. The unequal distribution of environmental hazards and resources stems from economic inequality, racial capitalism, structural racism, weak enforcement of environmental and public health regulations, and land-use decisions that exclude impacted and marginalized groups (Schusler et al., 2023). Focus group participants found poor environmental decision-making to be a result of public corruption and stagnant leadership, expressing criticism and concern about policies enabling forest destruction and environmental harm. Poor urban planning and lack of investment in green and public spaces were also highlighted as factors perpetuating environmental inequities. Issues such as industrial pollution, poor waste management, abandoned buildings, and unsafe infrastructure, like broken sidewalks, were identified as key problems. These hazards increase health risks and diminish the quality of life in affected neighborhoods.

Climate change

Climate change is one of the greatest global health threats. Research shows that people of color, including Black, Latine, Native American, Pacific Islander, and Asian communities, often face higher risks of climate-related health impacts than white populations (Berberian et al., 2022; Ihejirika, 2023; Patnaik et al., 2020). Studies have identified racial disparities in mortality, respiratory and cardiovascular diseases, mental health, and heat-related illnesses linked to climate changes (Berberian et al., 2022; Ihejirika, 2023; Patnaik et al., 2020). Children are especially vulnerable, with infants and children of color experiencing adverse perinatal outcomes, occupational heat stress, and increased emergency visits due to extreme weather (Berberian et al., 2022) Climate change is an environmental injustice that worsens racial and ethnic health inequities (Berberian et al., 2022). Communities of color are more vulnerable to its impacts due to systemic disinvestment and inequities in social, economic, and structural determinants of health such as limited access to quality housing and food (Berberian et al., 2022; Ihejirika, 2023; Patnaik et al., 2020). When developing strategies to improve community health, it is essential to consider community resilience, and the current and future impacts of climate change.

Built environment

The built environment refers to the man-made structures and spaces that form a community, including buildings, roads, sidewalks, parks, schools, transportation systems, and infrastructure. Multiple focus groups identified outdoor spaces, transportation options, and a safe neighborhood environment as the top benefits of their communities. Access to green spaces and housing were also recognized as key factors promoting health in communities. However, participants highlighted how these benefits are not equally distributed. Racist policies like redlining have created inequities in the built environment, leading to segregated communities, poor housing, unwalkable neighborhoods, and widespread disadvantage (Yang et al., 2023). These differences in the built environment can have direct impacts on health outcomes.

Transportation

Transportation is an important determinant of health as it influences a community's ability to access important needs such as jobs, healthy foods, healthcare, education, social activities, faith-based institutions, and essential services. When quality transportation options were available in their communities, focus group participants often praised them as one of the best things about their community. In other communities, participants noted concerns about unsafe sidewalks, lack of pedestrian crossings, and dangerous intersections. Issues such as severely broken sidewalks were cited as significantly hindering mobility for residents living with disabilities and older adults. The absence of bike lanes and bike-friendly roads in some communities makes cycling unsafe and impractical for many, including children. Additionally, limited access to safe and reliable transportation was frequently mentioned as a barrier to accessing healthcare for children and adults.

> “Transportation is something that has become really difficult. Because if you’re trying to utilize public transportation, the closest train station to us has been in construction for, I want to say over five years. And they just still haven’t fixed the stop. So, you have to walk all the way to the next stop to catch it. And then also any of the buses that you want to take because of construction on the roads, the buses reroute.”
>
> — NAMI Metro Suburban focus group participant

Active transportation

Active transportation, such as walking, biking, and riding public transportation, benefits health in many ways. It is associated with fewer premature deaths, heart attacks, asthma attacks, cases of bronchitis, respiratory-related emergency department visits, and missed workdays (Filigrana et al., 2022; Mizdrak et al., 2019; National Recreation and Park Association, 2013; Schweninger et al., 2021). These benefits stem from the reduced air pollution, increased physical activity, and improved mental well-being linked to active transportation. As a result, investing in evidence-based active transportation strategies can lower healthcare costs, improve community health and well-being, and reduce health inequities. (Filigrana et al., 2022; Mizdrak et al., 2019; Schweninger et al., 2021).

Chicago and Cook County have higher rates of active transportation (walking, biking, and public transportation) to work compared to the United States overall (Figure 61). In Cook County, 18% of residents aged 16 or older use active transportation for commuting, while in Chicago, more than 25% rely on active transportation for their work commute.

Active transportation declined during the COVID-19 pandemic and shutdowns. While rates have steadily increased since 2021, they remain below pre-pandemic levels (Figure 62). Similar trends are seen for commuters taking public transportation to work (Figure 64Figure 65).

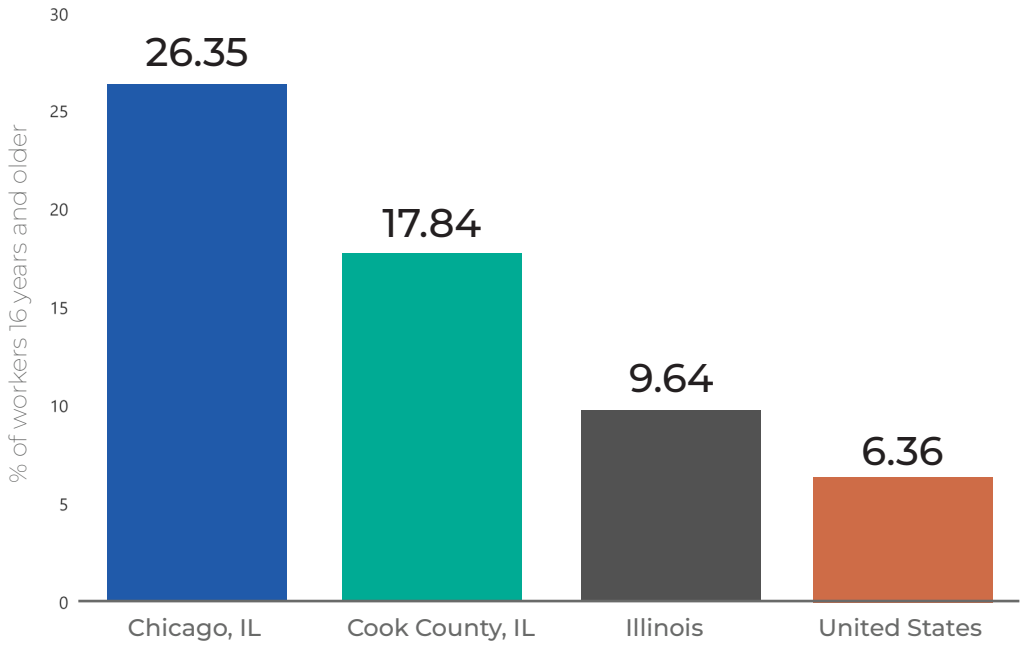


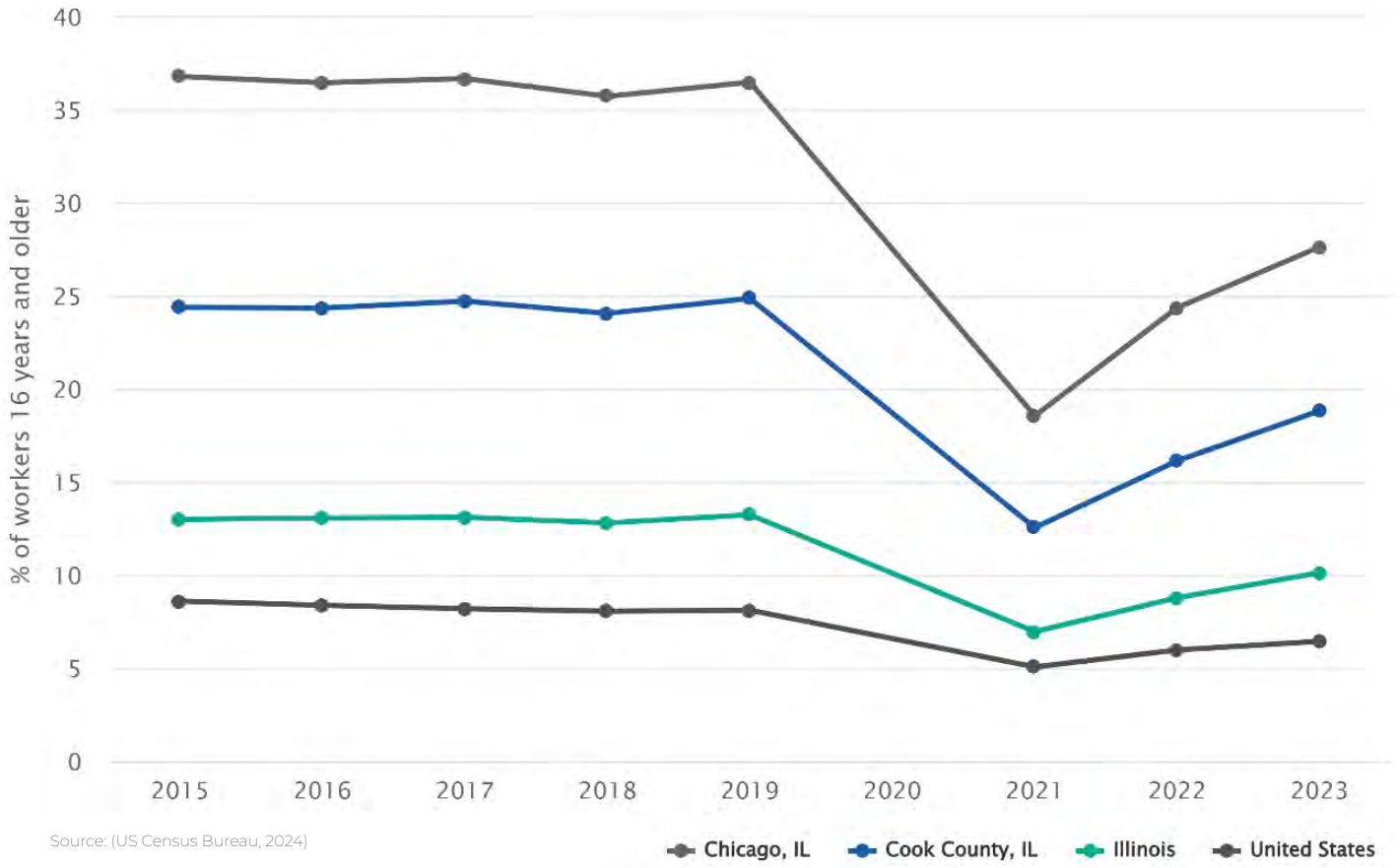
Figure 61.

Chart of commuters using active transportation to work as a percentage of workers 16 years and older in Chicago, Illinois, 2019-2023

Source: (US Census Bureau, 2024)

Figure 62.

Chart of commuters using active transportation to work as a percentage of workers over 16 years old over time in Chicago, Illinois 2015-2023



Source: (US Census Bureau, 2024)

Figure 63.

Chart of commuters taking public transportation to work as a percentage of workers 16 years and older in Chicago, Illinois, 2019-2023

Source: (US Census Bureau, 2024)

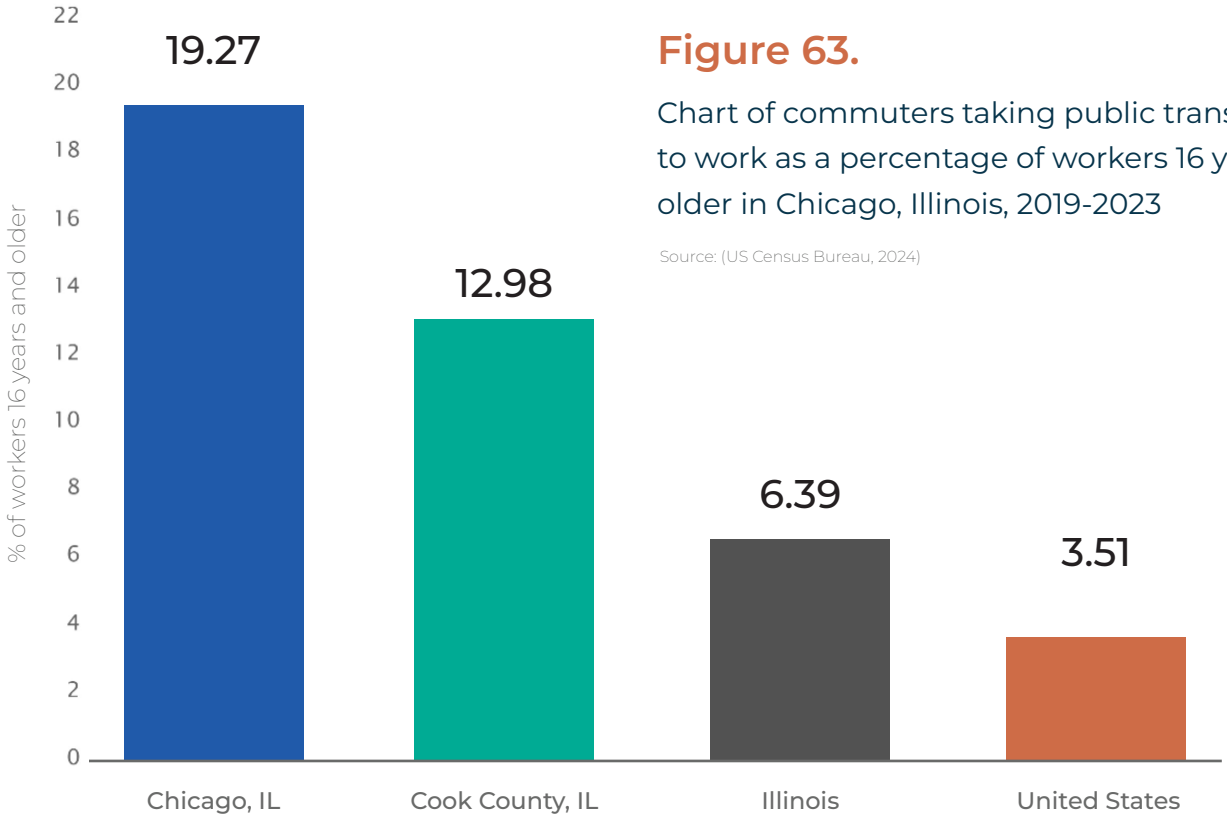
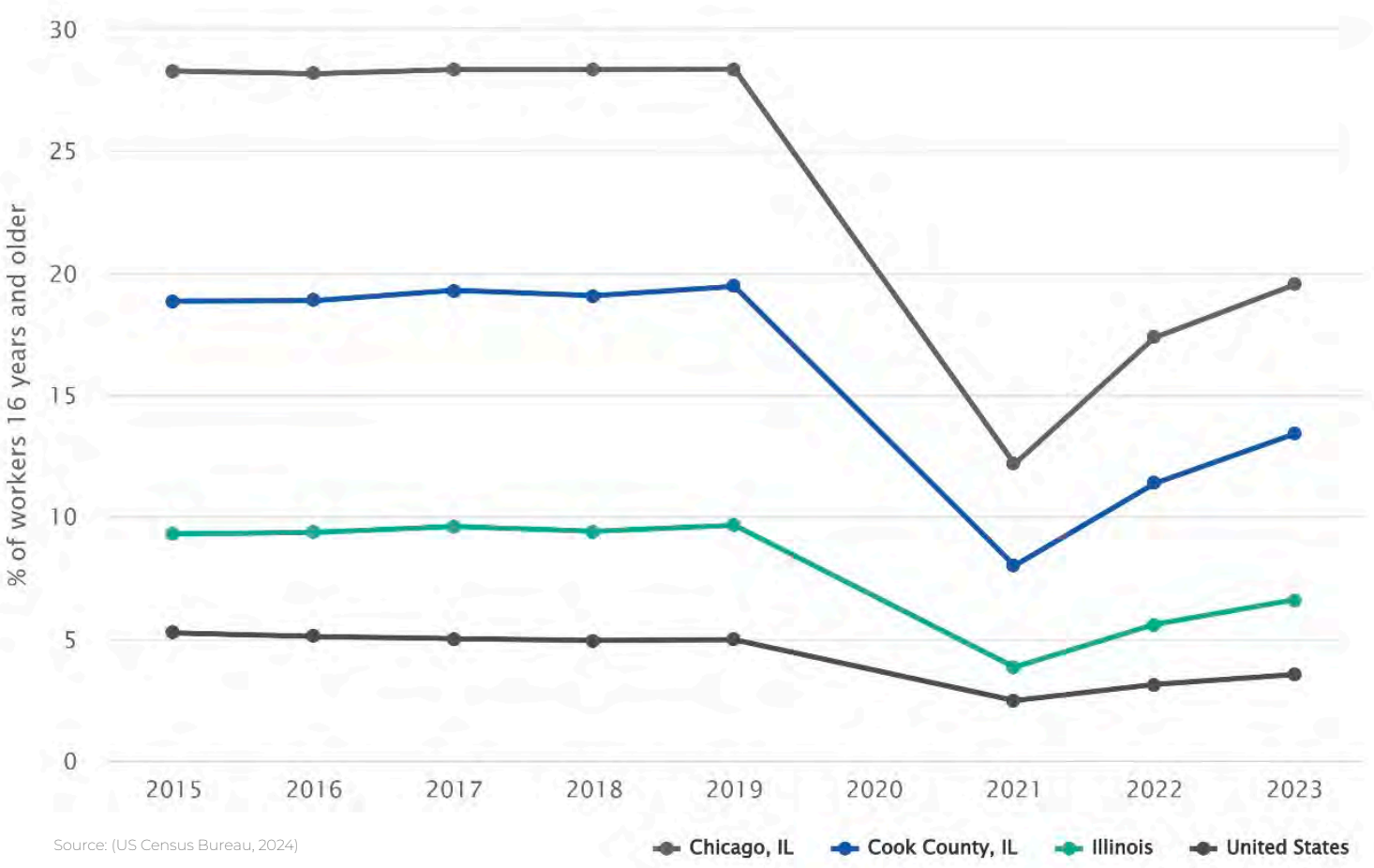


Figure 64.

Chart of commuters taking public transportation to work as a percentage of workers 16 years and older over time in Chicago, Illinois, 2015-2023



Source: (US Census Bureau, 2024)

Access to public transportation and other active transportation methods is especially important for Cook County residents, as a higher percentage of households lack a vehicle compared to the national average (Figure 65). Focus group participants described how unreliable or unavailable public transit and specialized medical transport services make it difficult for residents without personal vehicles to access healthcare, and also noted that the cost of transportation can be an additional burden.

> "The closest specialist is miles away, and if you don't have a car, it's almost impossible to get there."
>
> — NAMI Metro Suburban focus group participant

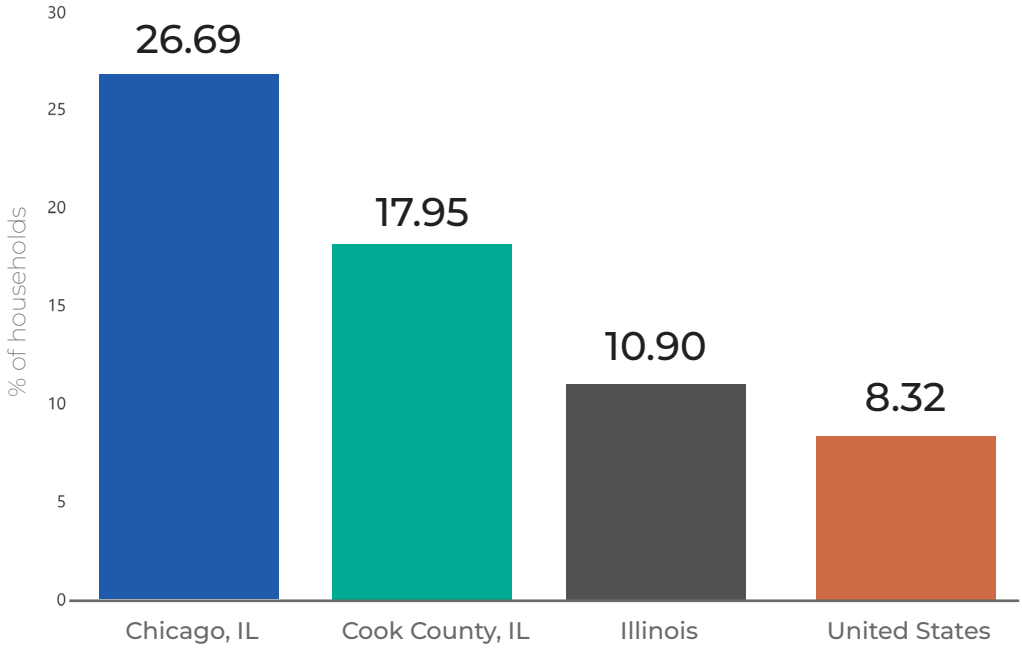


Figure 65.

Chart of households with no vehicle available as a percentage of households in Chicago, Illinois, 2019-2023

Source: (US Census Bureau, 2024)

Focus group participants suggested several transportation-related strategies to improve health, including expanding infrastructure in underserved areas and creating programs to make transportation more affordable and reliable for healthcare access. They envisioned a future where dependable, affordable transportation connects residents to essential services and job opportunities.

Pollution

Air and water pollution, along with other environmental contaminants, significantly impact health by:

- increasing rates of respiratory diseases, such as asthma
- raising risks of heart disease, heart attacks, and stroke
- contributing to reproductive, immune, and neurological disorders
- elevating cancer rates
- increasing rates of chronic conditions like obesity and diabetes.

As previously mentioned, low-income communities, communities of color, and communities on the south and west sides of the county have the highest exposures to environmental hazards. This compounds health inequities within these communities. Community residents that participated in focus groups further stressed the importance of clean water, safe housing, and environmental protections.

Air quality

The connection between air quality and health is well established. Exposure to pollutants like ozone and PM2.5 increases the risk of lung irritation, respiratory issues, cardiovascular disease, asthma, cancer, and premature death (Chicago Department of Public Health, 2020). Focus group participants connected asthma in their communities to environmental factors like poor outdoor air quality and housing conditions that harm indoor air quality.

A recent report by the American Lung Association found that the Chicagoland area has some of the worst air quality in the nation (American Lung Association, 2024). The Respiratory Hazard Environmental Justice Index reveals varying levels of airborne toxin exposure across Cook County, IL (Figure 66). Some areas rank in the 90th percentile nationally, indicating significantly higher exposure and environmental burden. These findings highlight the need for targeted interventions to promote environmental justice.

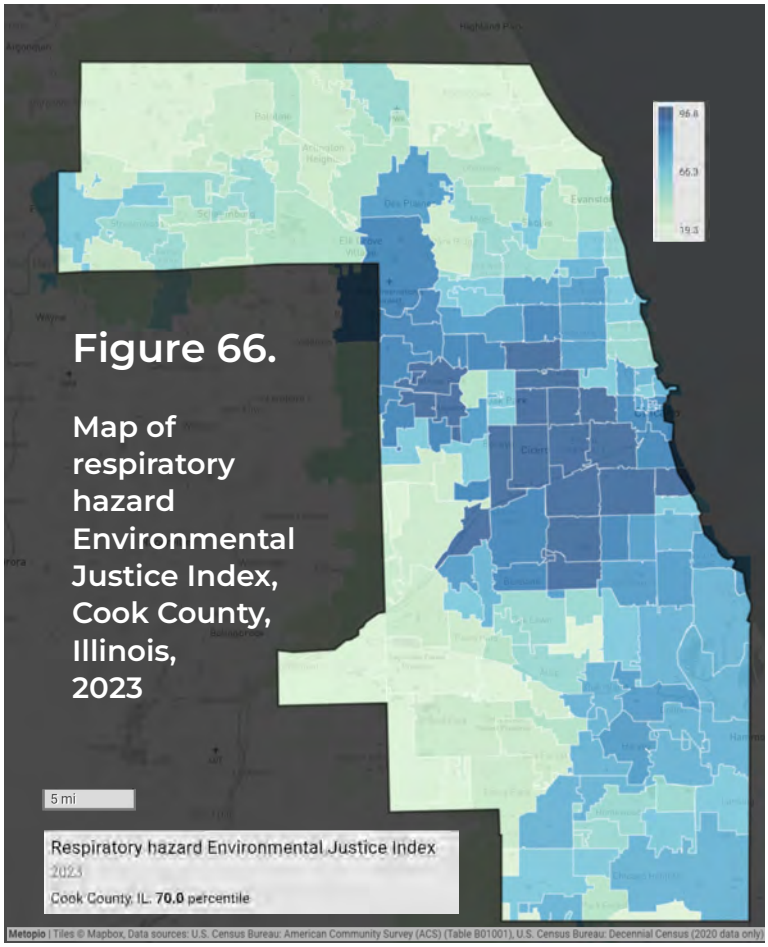


Figure 66.

Map of respiratory hazard Environmental Justice Index, Cook County, Illinois, 2023

Source: (United States Environmental Protection Agency, 2024)

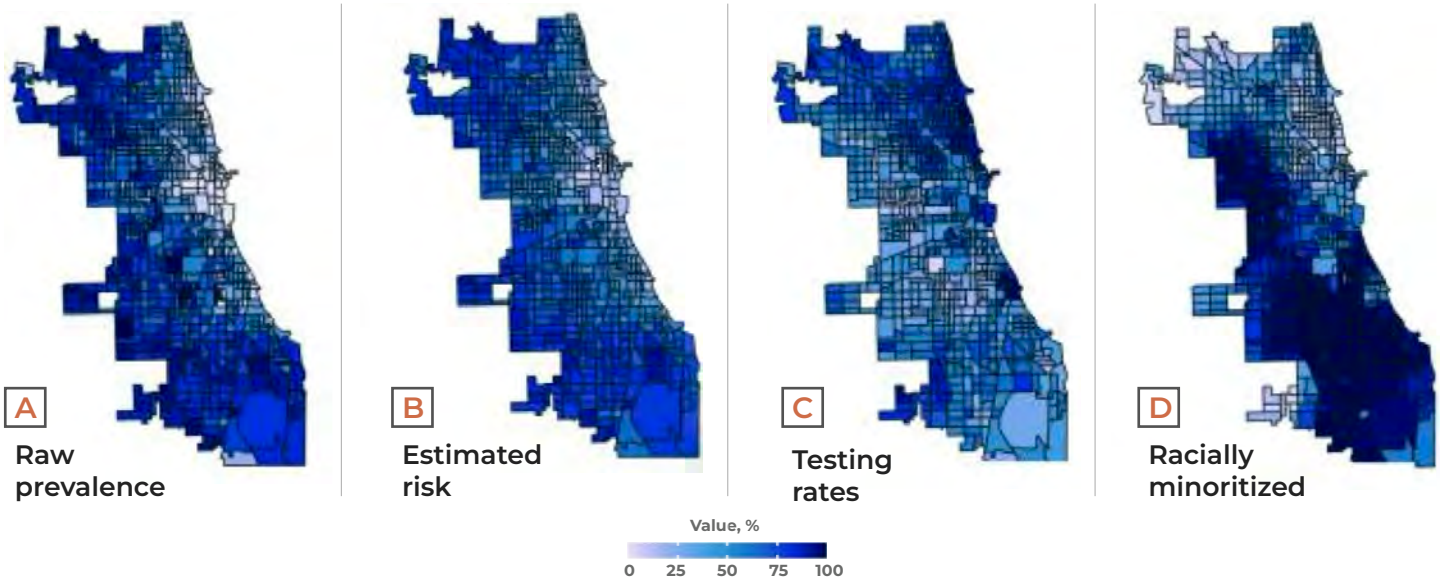
Water quality

Water contaminants pose serious health risks, with lead in drinking water remaining a major concern in Cook County. In Chicago, an estimated 68% of children under 6 years old are exposed to lead-contaminated water (Figure 67), and 19% rely on unfiltered tap water as their primary water source (Huynh et al., 2024). Predominantly Black and Hispanic neighborhoods are disproportionately exposed to contaminated water and are less likely to receive lead testing (Huynh et al., 2024). Lead exposure poses serious health risks, especially for children, including developmental delays, cardiovascular issues, chronic kidney disease, and neurological problems (Huynh et al., 2024). Focus group participants echoed concerns about lead exposure and its impact on community health, particularly for children.

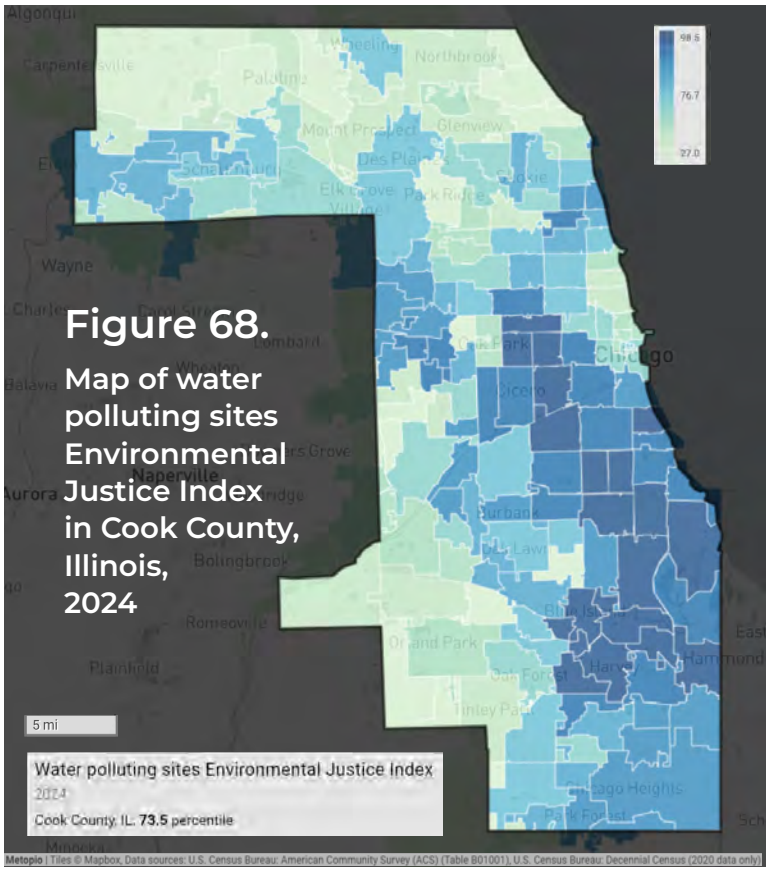
Figure 67.

Map of child population under 6 years exposed to lead contaminated drinking water as a percentage of child population by race and ethnicity, Chicago, Illinois, 2016-2023

Source: (Huynh et al., 2024)



Industry is another major contributor to water contamination in Cook County. The 2024 Water Polluting Sites Environmental Justice Index measures exposure risks based on proximity to polluting sites and population vulnerability, with scores ranging from 0 (lowest) to 100 (highest). The southern region of the county faces a particularly high burden, with some areas scoring as high as 99, indicating significant risk and vulnerability to water pollution (Figure 68). This underscores the legacy of environmental injustice within Cook County communities.



Source: (United States Environmental Protection Agency, 2024)

HEALTH BEHAVIORS

Four key health behaviors—smoking, physical inactivity, excessive alcohol use, and poor nutrition – are leading risk factors for development of chronic disease (K. Hacker, 2024). Social determinants of health, including food insecurity, financial barriers to care, and housing instability, are strongly associated with the ability to engage in healthy behaviors (K. Hacker, 2024).

Individual health behaviors often reflect coping mechanisms shaped by the environment. Research highlights that community investments and system-level solutions, such as safe parks, subsidized transportation, and improved financial stability, are key to promoting positive health behaviors like increased physical activity (Mudd et al., 2024).

Focus group participants highlighted personal practices like healthy eating, staying hydrated, and physical activities such as walking as integral to their sense of health and vitality. However, they also highlighted structural barriers like economic challenges, limited access to healthy foods, housing instability, unsafe neighborhoods, and a lack of safe play spaces and youth programs, including sports, as obstacles to positive health behaviors in their communities.

In Cook County, the age-adjusted prevalence of residents at higher risk for chronic disease due to the core health behaviors mirrors national rates (Figure 69). However, significant geographic disparities exist, particularly on the West and South Sides of Chicago (Figure 70 and Figure 71), where additional structural barriers hinder preventive health efforts.

Figure 69.

Table of adult health behaviors in Cook County, Illinois, 2021-2022

HEALTH BEHAVIOR	CHICAGO	COOK COUNTY	ILLINOIS	UNITED STATES
Percentage of adults that reported no exercise the last month (2022)	23.7%	20.9%	21.5%	23.7%
Percent of adults that smoke cigarettes (2022)	14.1%	12.0%	13.5%	14.6%
Percent of adults who report binge drinking (2022)	20.7%	20.8%	20.4%	18.6%
Percent of adults that eat the recommended servings of fruits and vegetables (2021)	-	-	6.2%	7.4%

Source: (Centers for Disease Control and Prevention, 2024r)

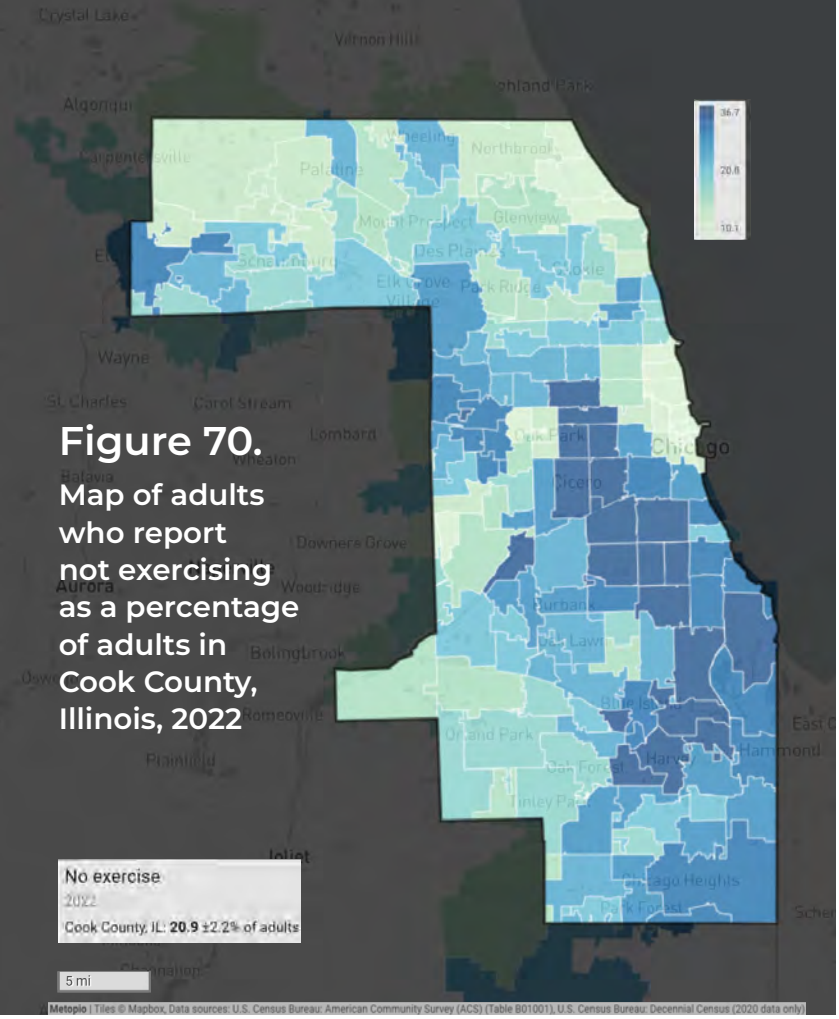


Figure 70.

Map of adults who report not exercising as a percentage of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

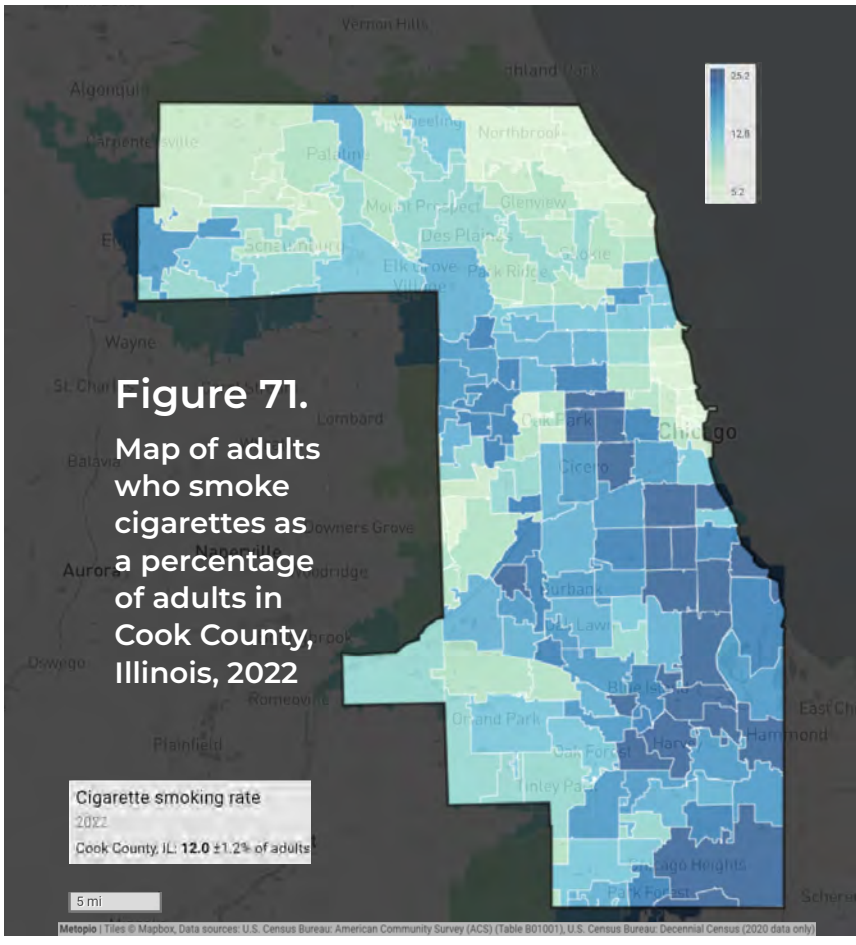


Figure 71.

Map of adults who smoke cigarettes as a percentage of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

Childhood and adolescence are a critical development period. The patterns established during this time help determine current health status and the risk of developing chronic diseases, disability, and premature death. For example, individuals under eighteen who use e-cigarettes are three times more likely to start smoking traditional cigarettes within two years compared to those who do not (UCLA Health, 2018). Smoking dramatically increases the risks for conditions such as heart disease, stroke, and chronic respiratory disease. In addition, less than a quarter of youth in Illinois reported adequate levels of preventative health behaviors such as engaging in recommended levels of physical activity (Figure 72).

Less than a quarter of youth in Illinois reported adequate levels of preventative health behaviors such as engaging in recommended levels of physical activity (Figure 72).

Figure 72.

Table of youth health behaviors in Cook County, Illinois, 2021

PERCENT OF 10TH GRADE STUDENTS (2024)	CHICAGO	SUBURBAN COOK COUNTY	ILLINOIS
Eat recommended servings of fruit in the last 7 days	13%	9%	9%
Eat recommended servings of vegetables in the last 7 days	11%	9%	9%
No exercise in the last 7 days	16%	6%	9%
Binge drinking in the last 14 days	4%	4%	4%
Vape in the last 30 days	6%	6%	4%
Smoked cigarettes in the last 30 days	0%	1%	1%

Source: (Illinois Department of Human Services, 2024b, 2024c, 2024a)

CHRONIC CONDITIONS

A chronic condition is a long-term physical or mental health issue lasting a year or more that requires ongoing care or limits daily activities. Chronic diseases are the leading cause of disability and death globally and in the United States, where 60% of adults have one chronic condition and 40% have two or more chronic conditions (Centers for Disease Control and Prevention, 2024a). Heart disease, cancer, and diabetes are the top causes of death and major contributors to the nation's $4.5 trillion annual healthcare costs (Centers for Disease Control and Prevention, 2024a). Effective prevention and management can greatly reduce their impact on individuals and society. While prevention is the ultimate goal, funding for chronic disease treatment has historically far exceeded funding for prevention.

Many community input survey respondents ranked chronic conditions as top health issues in their community. Diabetes, obesity, age-related physical illness, heart disease, and stroke all ranked in the top ten (Figure 73).

Figure 73.

Table of chronic conditions selected as the biggest health issues by survey respondents (n=1791)

HEALTH ISSUE	PERCENT
Diabetes	22.1%
Obesity	18.9%
Age-related physical illnesses	17.3%
Heart disease and stroke	10.5%
Cancers	9.7%
Chronic pain	6.1%
COVID-19 pandemic	4.8%
Cognitive conditions	4.7%
Lung disease	3.1%
Sexually transmitted infections	2.8%

> “We ain’t got no gym here. We ain’t got no food here. We ain’t healthy”
>
> — NAMI Metro Suburban focus group participant

Focus group discussions highlighted several chronic conditions that are significant concerns for communities in Cook County. Participants linked these conditions to systemic issues such as delayed or inadequate care, financial burdens, and lifestyle and environmental factors.

OBESITY

Obesity, a chronic condition measured by the ratio of height to weight, is influenced by factors such as limited access to healthy food and safe spaces for physical activity, poor sleep quality, stress, genetics, and certain health conditions or medications. It increases the risk of health issues like high blood pressure, type 2 diabetes, and some cancers (Centers for Disease Control and Prevention, 2024d).

Obesity rates have been climbing for more than 20 years. In 2022, rates for adult obesity in Cook County were comparable to the state and national rates (Figure 74). Rates are highest on the South and West Sides of Chicago and in the south suburbs (Figure 75). As previously mentioned, higher obesity rates are linked to socio-economic factors such as poverty, access to healthy foods, access to green space, and access to healthcare (Y. Huang & Sparks, 2023).

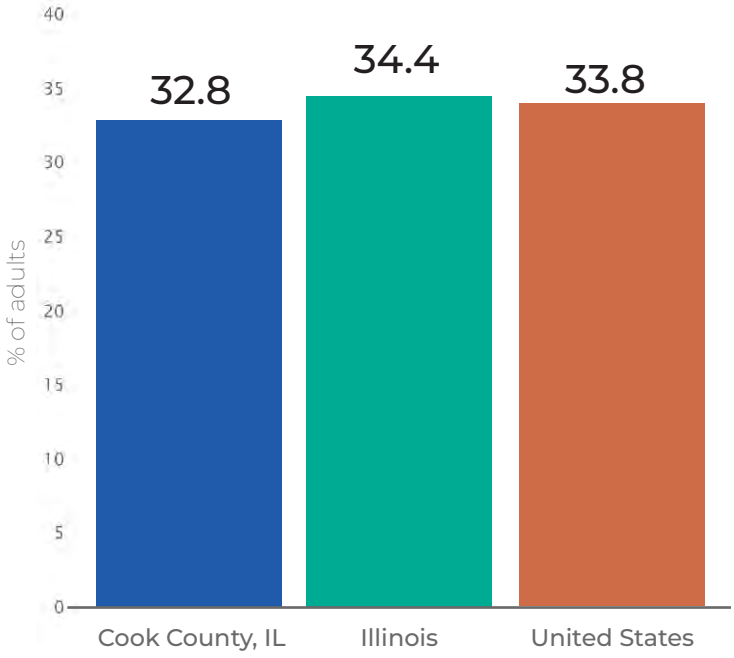
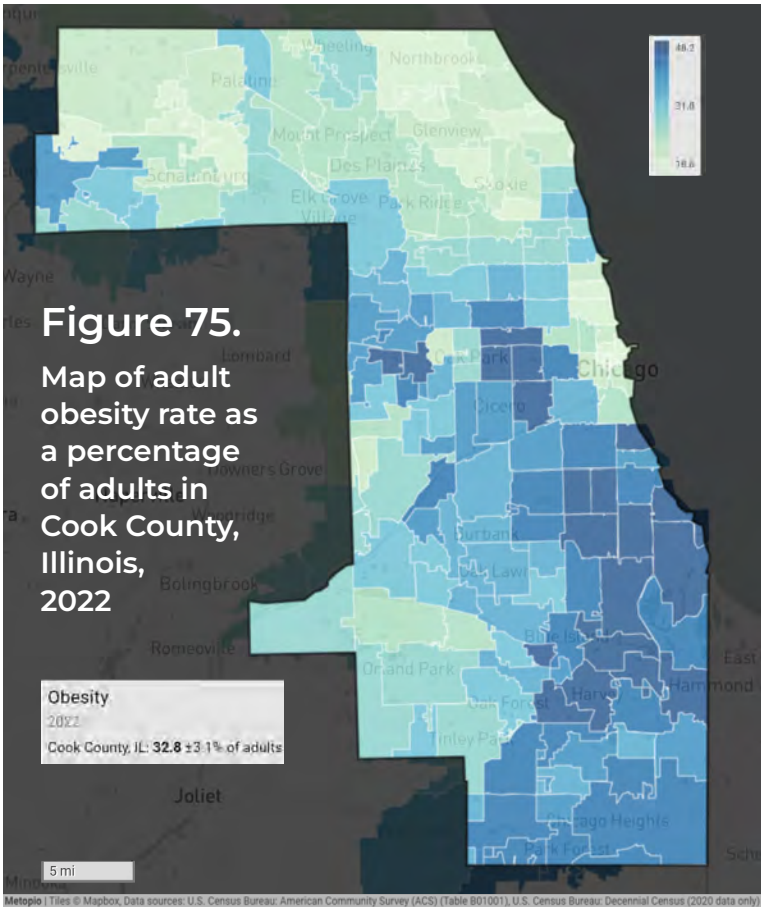


Figure 74.

Chart of obesity rate as a percentage of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

Community input survey respondents rated obesity as a top health issue in their community, with 19% selecting it as one of their top 3 priorities.



Source: (Centers for Disease Control and Prevention, 2024q)

Youth obesity increases the risk of obesity in adulthood (Centers for Disease Control and Prevention, 2024d). Obesity rates for children aged 6-17 are similar in Illinois and the United States (Figure 76). However, rates are significantly higher among children living below 200% of the federal poverty line (Figure 76).

Figure 76.

Table of obesity rate as a percentage of youth aged 6-17 by income level in Illinois, 2022-2023

	ILLINOIS (% OF YOUTH AGED 6-17)	UNITED STATES (% OF YOUTH AGED 6-17)
Overall rate	17.0%	17.0%
Less than 100% below federal poverty level	24.8%	23.8%
100-199% below federal poverty level	26.6%	21.7%
200%-399% below poverty level	18.4%	17.5%
400% or more poverty level	7.2%	10.4%

Source: (Child and Adolescent Health Measurement Initiative, 2025)

DIABETES

Diabetes is a condition in which the body has a decreased ability to produce or use insulin, leading to high blood glucose (blood sugar). People with unmanaged diabetes are at risk of complications such as heart disease, vision loss, and kidney disease (Illinois Department of Public Health, 2021a). People with diabetes pay more than twice as much in medical costs than those without diabetes and their risk of early death is 60% higher (Illinois Department of Public Health, 2021a). Diabetes can be prevented and managed with lifestyle changes and medications (Centers for Disease Control and Prevention, 2024a).

Rates of diabetes in Cook County are comparable to state and national rates (Figure 77). Within Cook County, diabetes is most prevalent in the western and southern regions (Figure 78). As with other chronic conditions, increased prevalence of diabetes is linked to race and ethnicity, sex, and socioeconomic factors such as poverty, access to healthy foods, access to green space, and access to testing (Centers for Disease Control and Prevention, 2024a). These inequities lead to not only higher prevalence rates, but higher rates of diabetes-related emergency department visits, hospitalizations, and deaths.

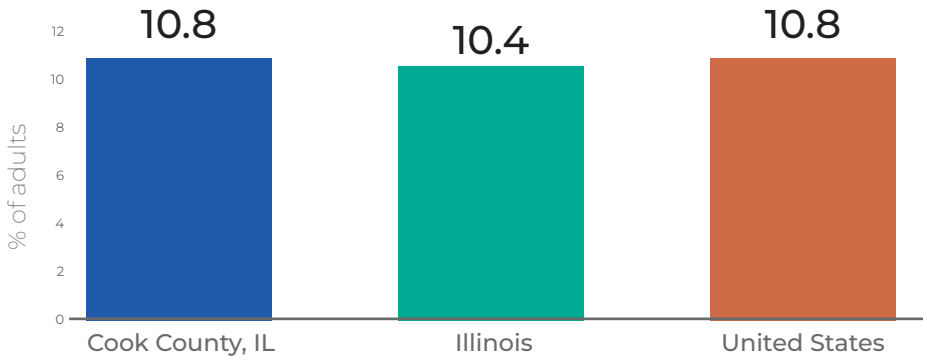


Figure 77.

Chart of diagnosed diabetes rate as a percentage of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

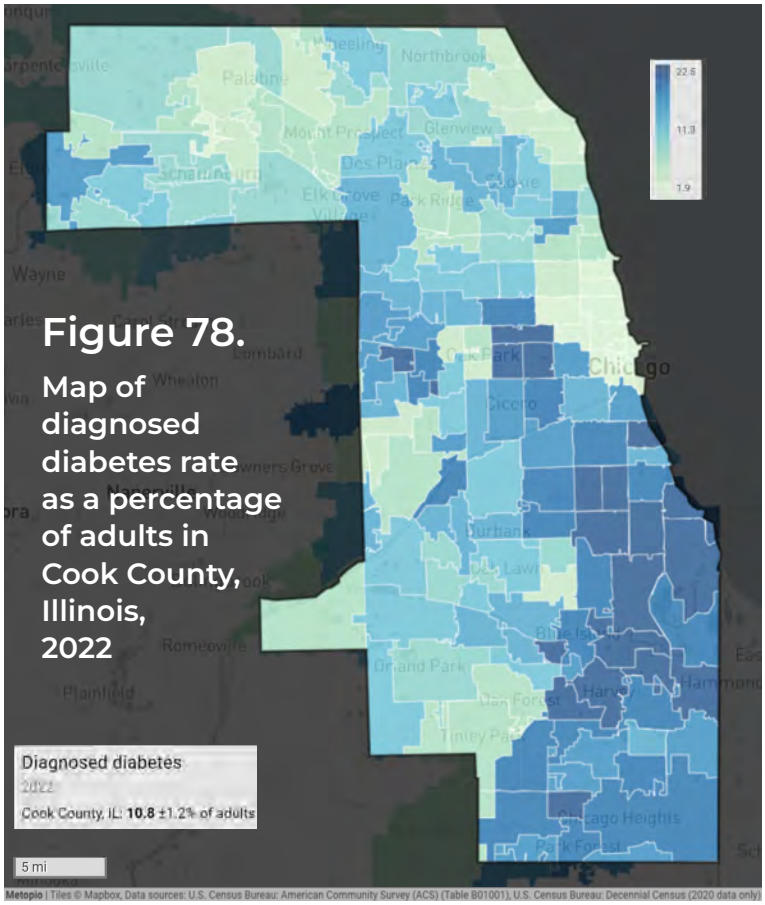


Figure 78.

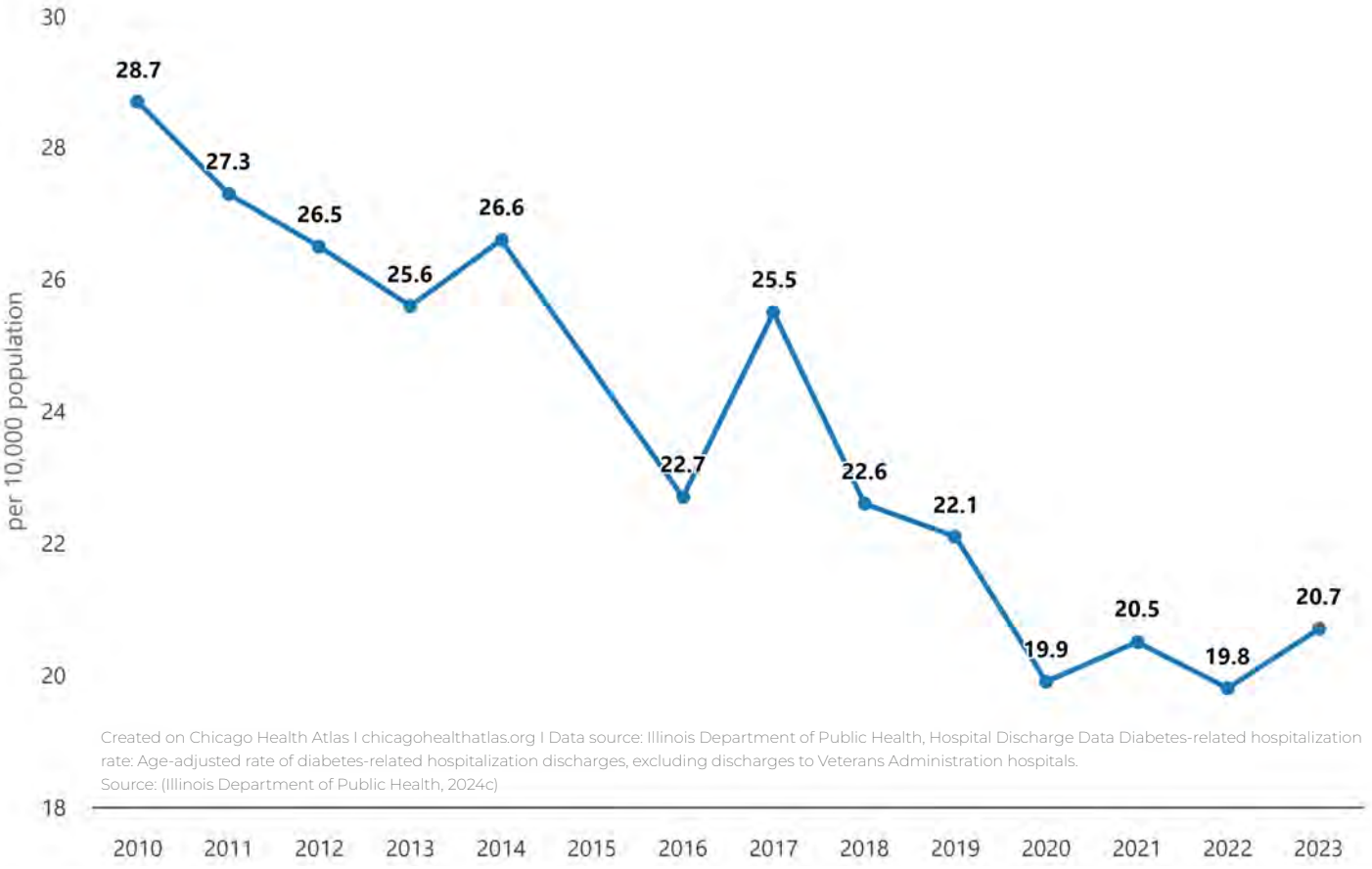
Map of diagnosed diabetes rate as a percentage of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

Hospitalizations for diabetes reflect both individual health and the effectiveness of community-based management and treatment. While hospitalization rates for diabetes have decreased over time in both Chicago and Suburban Cook County, Black residents continue to experience significantly higher rates of diabetes-related hospitalizations (Figure 79 and Figure 82).

Figure 79.

Chart of diabetes-related hospitalization rate per 10,000 population over time in Chicago, Illinois, 2010-2023



Created on Chicago Health Atlas I chicagohealthatlas.org I Data source: Illinois Department of Public Health, Hospital Discharge Data Diabetes-related hospitalization rate: Age-adjusted rate of diabetes-related hospitalization discharges, excluding discharges to Veterans Administration hospitals.
Source: (Illinois Department of Public Health, 2024c)

Figure 80.

Chart of diabetes-related hospitalization rates per 100,000 residents over time in Suburban Cook County, Illinois, 2016-2022

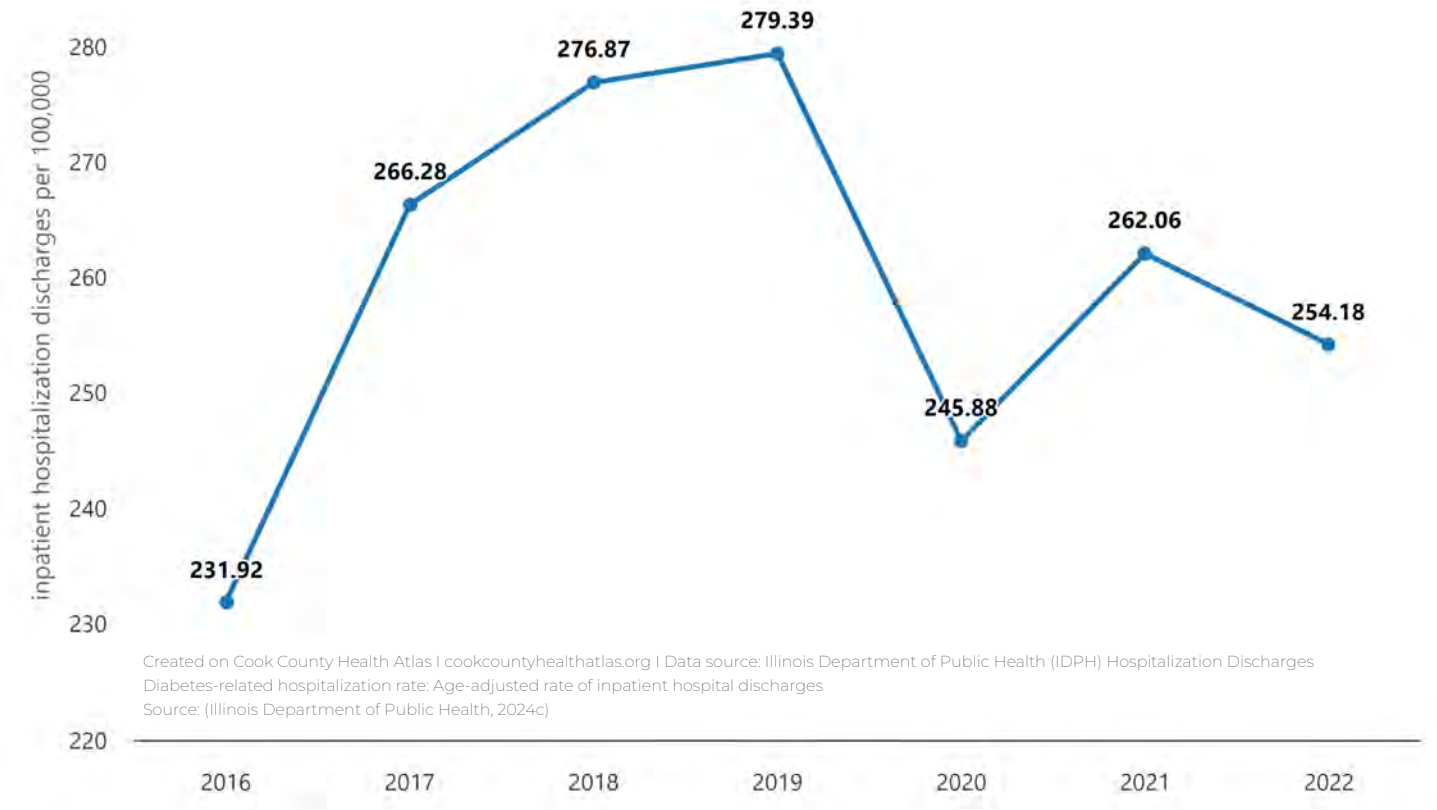
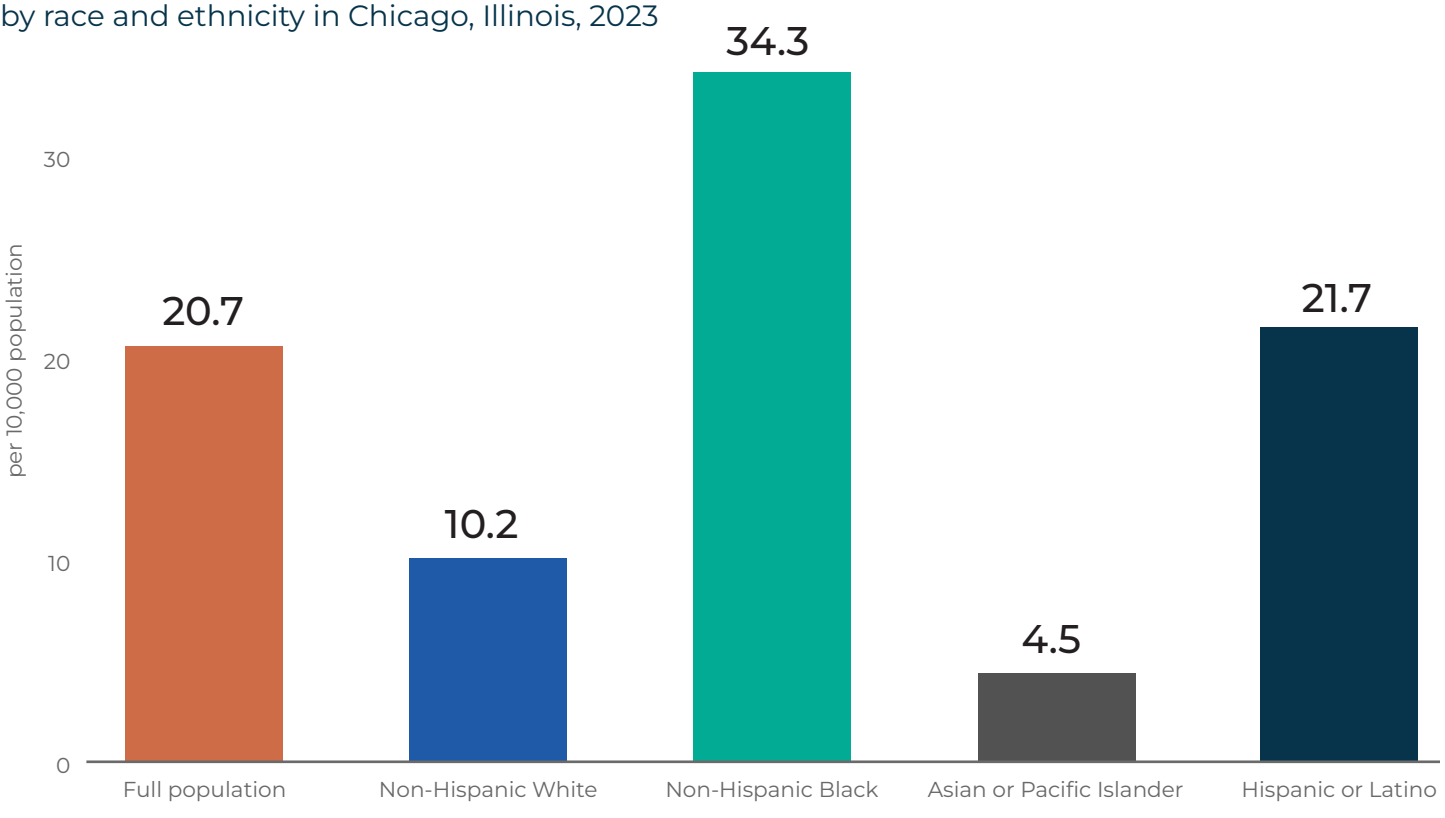


Figure 81.

Chart of diabetes-related hospitalization rate per 10,000 population by race and ethnicity in Chicago, Illinois, 2023

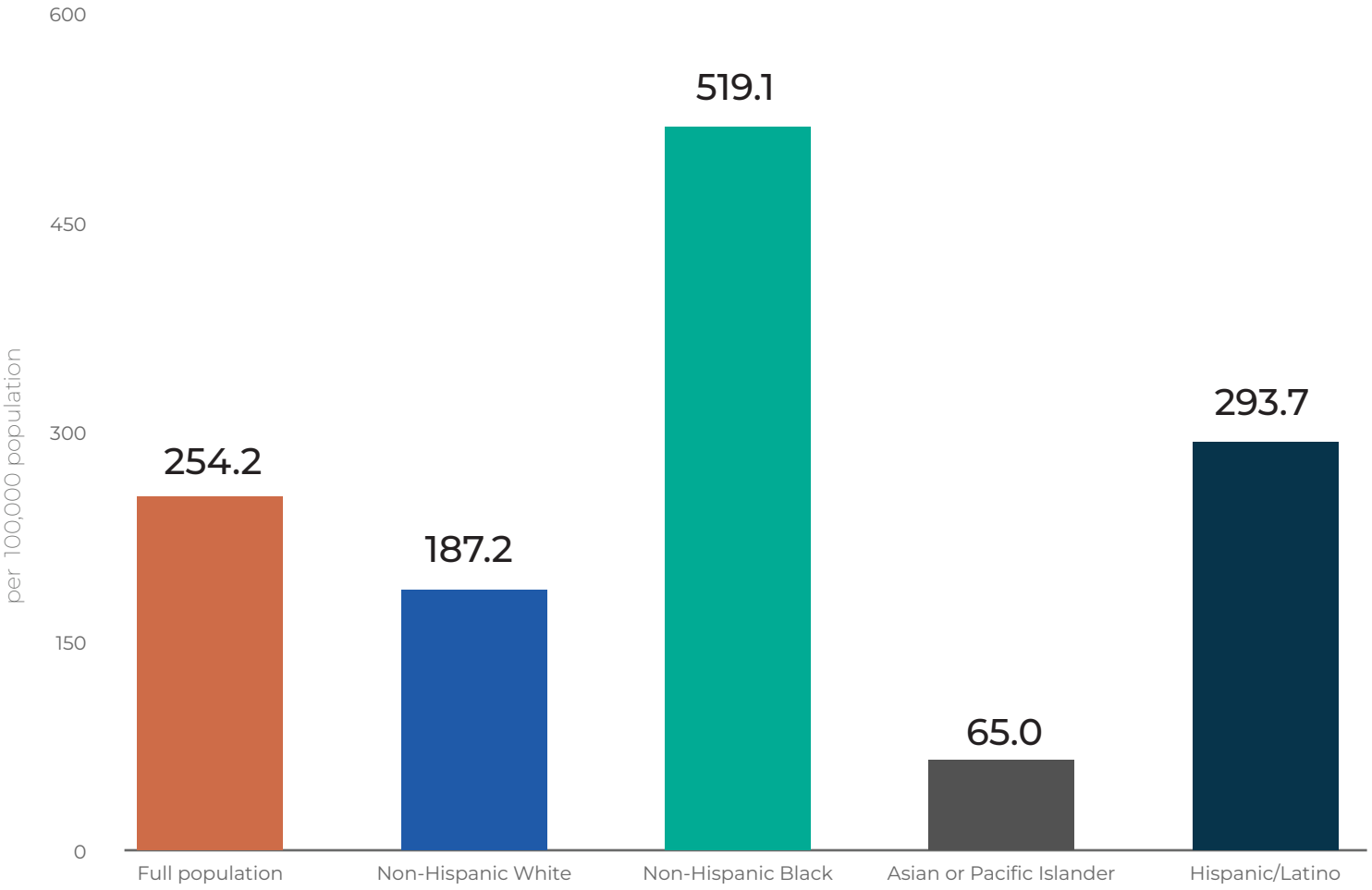


Source: (Illinois Department of Public Health, 2024c)

Figure 82.

Chart of diabetes-related hospitalization rate per 100,000 population by race and ethnicity in Suburban Cook County, Illinois, 2022

Source: (Illinois Department of Public Health, 2024c)



The diabetes mortality rate for Cook County is slightly higher than rates in Illinois and the United States (Figure 83). As with other indicators, mortality rates in the county are highest for Non-Hispanic Black individuals at 43.6 deaths per 100,000 population. This is almost twice the mortality rate of non-Hispanic white individuals at 22.2 per 100,000 population (Figure 84).

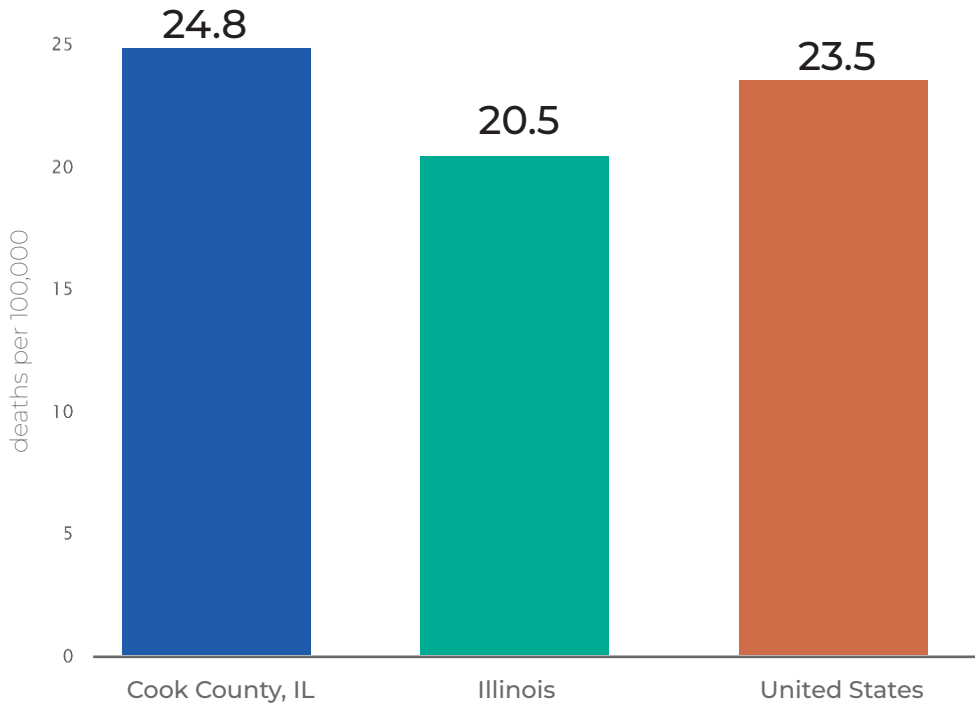


Figure 83.

Chart of diabetes mortality rate per 100,000 population in Cook County, Illinois, 2018-2022

Source: (Centers for Disease Control and Prevention, 2024o)

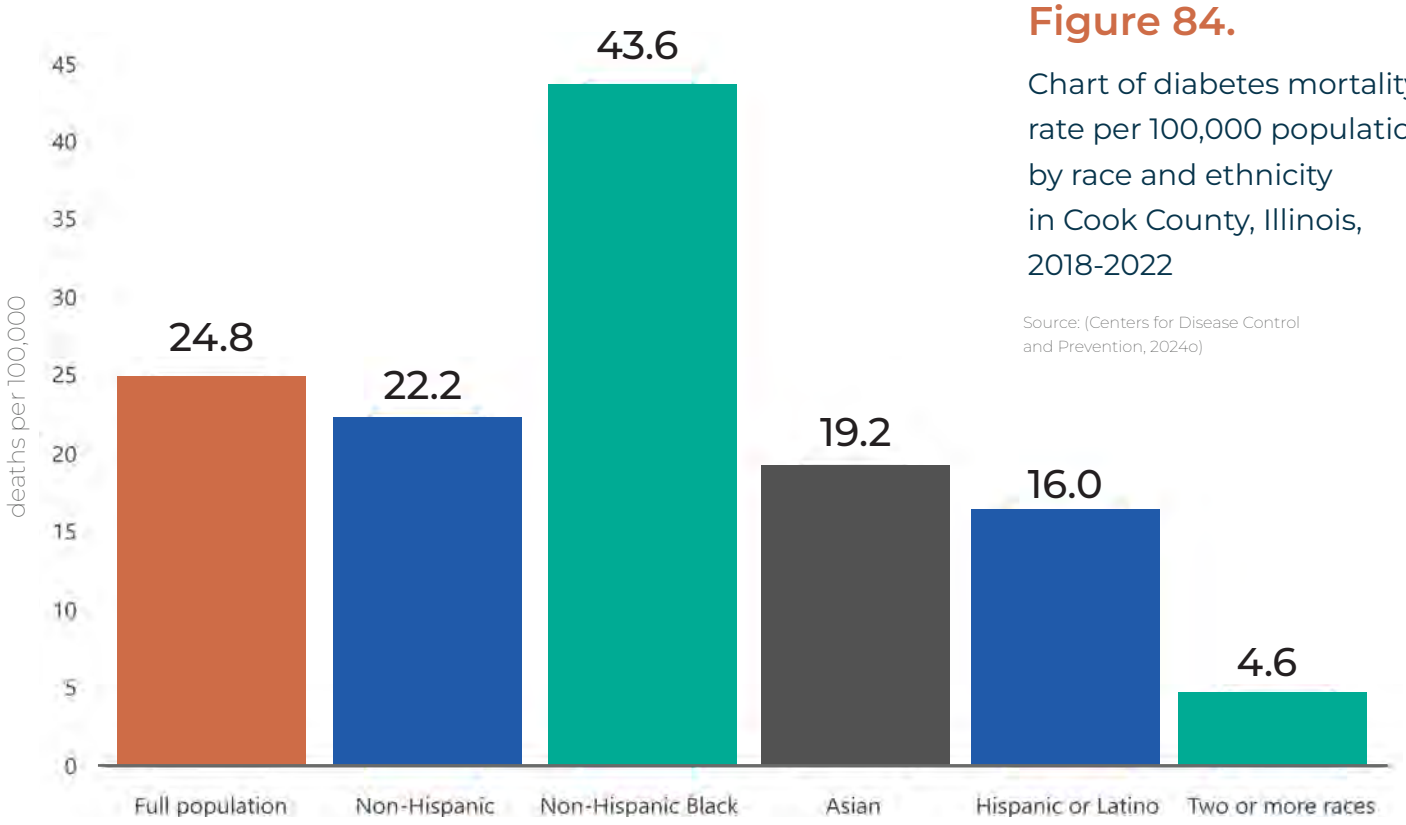


Figure 84.

Chart of diabetes mortality rate per 100,000 population by race and ethnicity in Cook County, Illinois, 2018-2022

Source: (Centers for Disease Control and Prevention, 2024o)

Among focus group participants, diabetes was frequently highlighted as a widespread issue, particularly in communities with limited access to healthy food and preventive care. Many expressed concerns about limited awareness of the importance of diet and exercise in managing the condition. Economic challenges, lack of access to affordable healthy food, and heavy marketing of unhealthy foods were identified as significant systemic barriers to diabetes prevention and management. Black and Brown communities were also described as having significant inequities in diabetes prevalence. These findings were reinforced by the community input survey; diabetes was selected as a top health concern by 22% of respondents, making it the second-highest health concern overall (Figure 73). Several factors that lower risk and help manage diabetes were selected as top health needs, including resources for food, easy access to quality healthcare services, walkable neighborhoods, diversity in healthcare providers, and parks and recreational spaces.

> "I think it would be beneficial and helpful you know if every person that was diagnosed with diabetes because even when I first got diagnosed, like I barely wanted to sit. It was no way I'm going to check my sugar by taking [it] myself and then tak[ing] the insulin, and then you got to do it like two, three times a day. So I wasn't taking care of it in the beginning, and I wasn't educated on it. But because of Beyond Hunger, you know I learned a lot about diabetes, how to control it, and how much you should eat, how much you shouldn't eat, what you should or shouldn't eat."
>
> — NAMI Metro Suburban focus group participant

> "Media like TV could be used to change people's behaviors. Advertise eating healthier foods like fresh produce, make it popular."
>
> — NAMI Metro Suburban focus group participant

CARDIOVASCULAR DISEASE

Globally, cardiovascular diseases such as high blood pressure, heart disease, and stroke are the leading cause of death. Various lifestyle and environmental factors contribute to risks for cardiovascular disease, such as air pollution, alcohol and tobacco use, unhealthy diet and lack of physical activity. Without treatment, cardiovascular disease can cause stroke, heart attack, and heart failure (World Health Organization, 2021).

Community input survey respondents rated cardiovascular disease as the tenth most important health issue in their community with 11% rating it in the top three.

Hypertension

High blood pressure is a sign of elevated risk for cardiovascular disease that can be tested at home or a healthcare facility (World Health Organization, 2021). High blood pressure rates in Cook County are similar to those in Illinois and the United States (Figure 85). However, the South and West Sides of Chicago and the south, far south, and southeast suburbs have higher rates (Figure 86). These areas, whose residents are predominantly non-white, have historically faced poverty, air pollution, and limited access to healthy food, green space, and healthcare due to segregation and systemic racism (H. Huang, 2022).

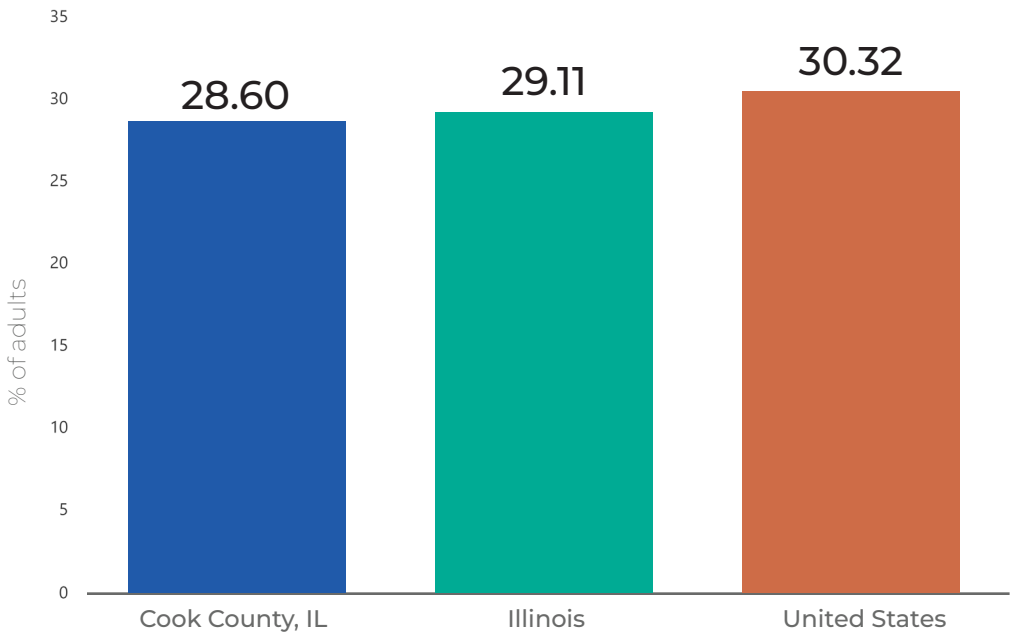
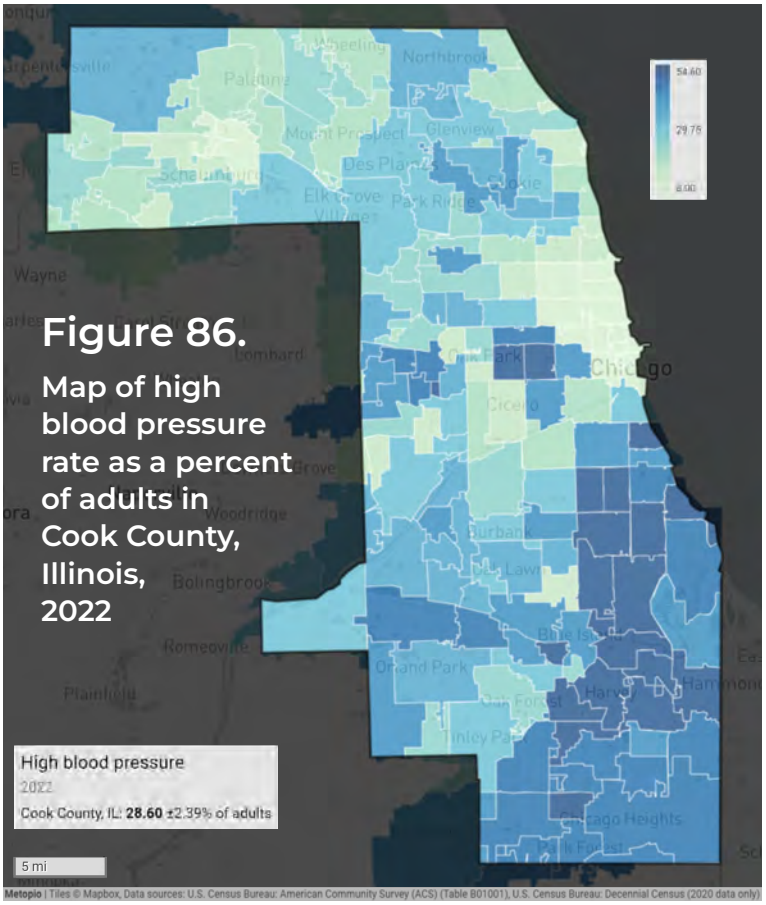


Figure 85.

Chart of rate of high blood pressure as a percent of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)



Source: (Centers for Disease Control and Prevention, 2024q)

Heart disease

Heart disease is the leading cause of death in the United States. Similar to other chronic conditions, risk factors for heart disease include high blood pressure, high cholesterol, smoking, diabetes, obesity, unhealthy diet, physical inactivity, and excessive alcohol consumption. The prevalence of coronary heart disease in Cook County is comparable to the rates for Illinois and the United States (Figure 87). However, there are disparities within Cook County between different racial and ethnic groups (Figure 88).

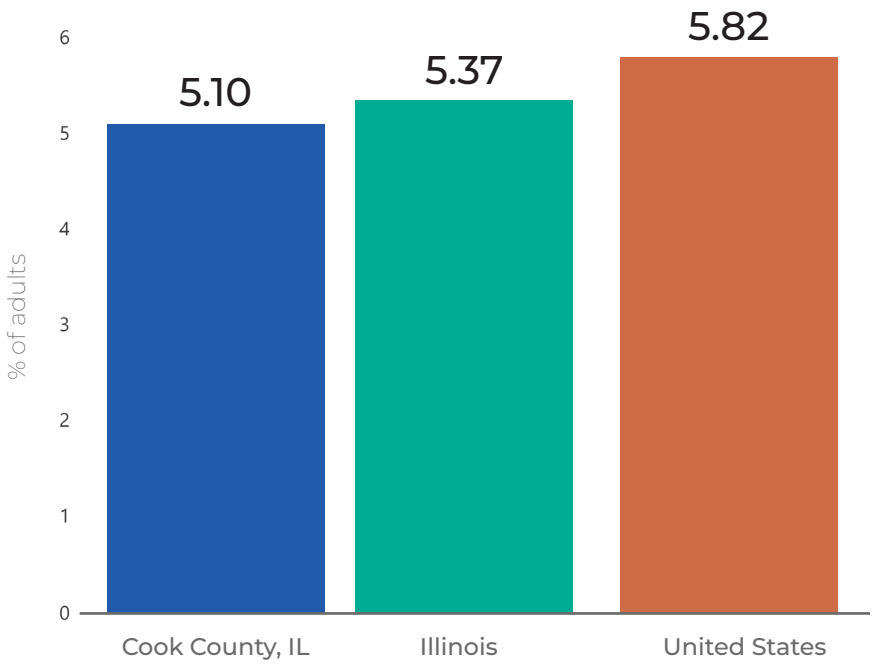


Figure 87.

Chart of coronary heart disease rate as a percent of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

Heart disease was mentioned by focus group participants in conjunction with hypertension (high blood pressure) and diabetes, highlighting the interconnectedness of these chronic conditions. They were reported as widespread conditions among adults, often linked to stress, poor diet, and lack of exercise. Limited access to routine checkups and blood pressure management tools were cited as exacerbating issues.

Following the trends for high blood pressure and diabetes, heart disease hospitalization rates for the county are highest in the west and south regions. Black residents have the highest burden of heart disease mortality (Figure 88).

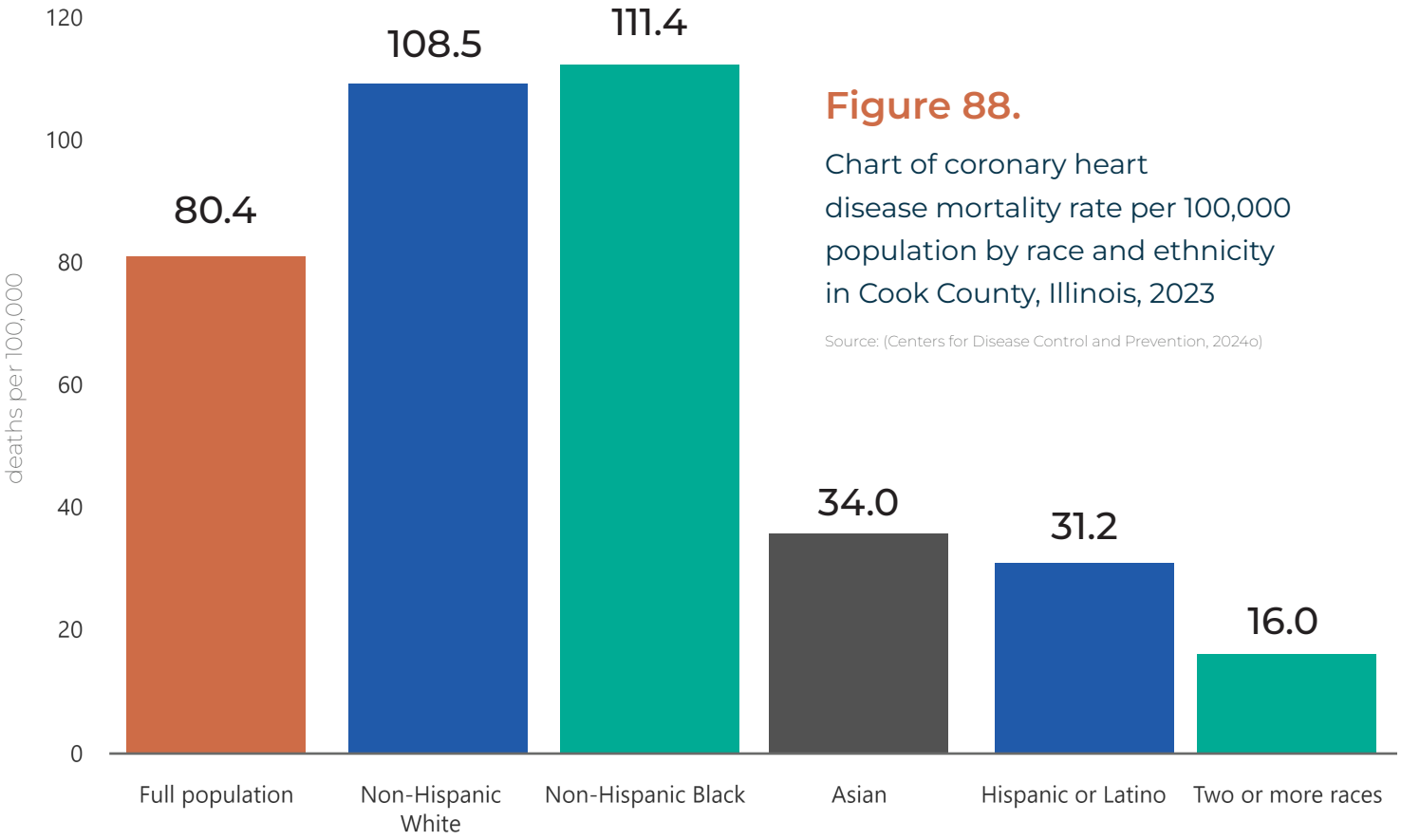


Figure 88.

Chart of coronary heart disease mortality rate per 100,000 population by race and ethnicity in Cook County, Illinois, 2023

Source: (Centers for Disease Control and Prevention, 2024o)

Stroke

A stroke occurs when blood supply to the brain is blocked or reduced. Stroke is a leading cause of death and disability in the United States. The rate of diagnosed strokes in Cook County is comparable to the rates for the state and nation overall (Figure 89). Consistent with other cardiovascular indicators, rates are highest on the South and West Sides of Chicago and in the south and west Suburbs (Figure 90).

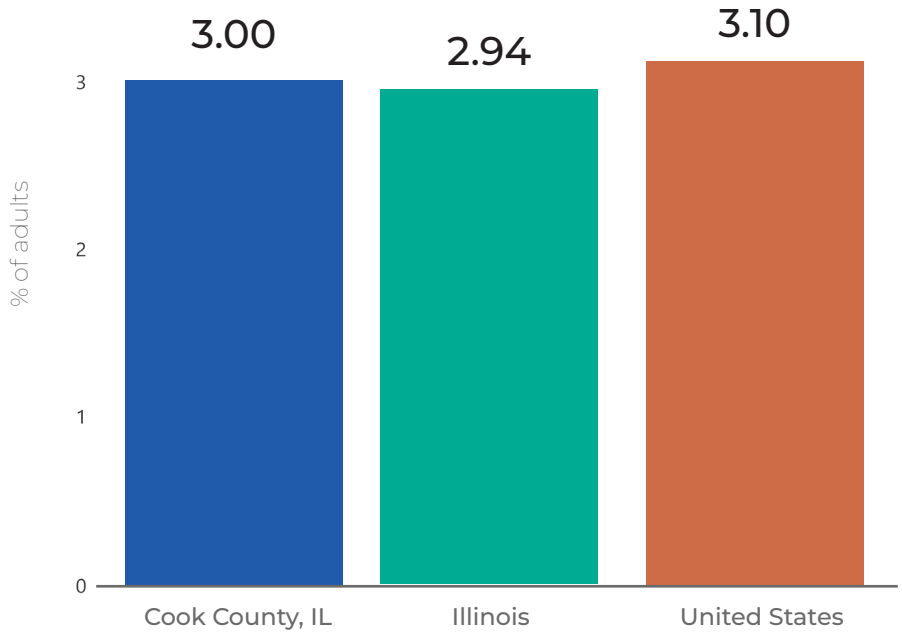


Figure 89.

Chart of diagnosed stroke rate as a percent of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

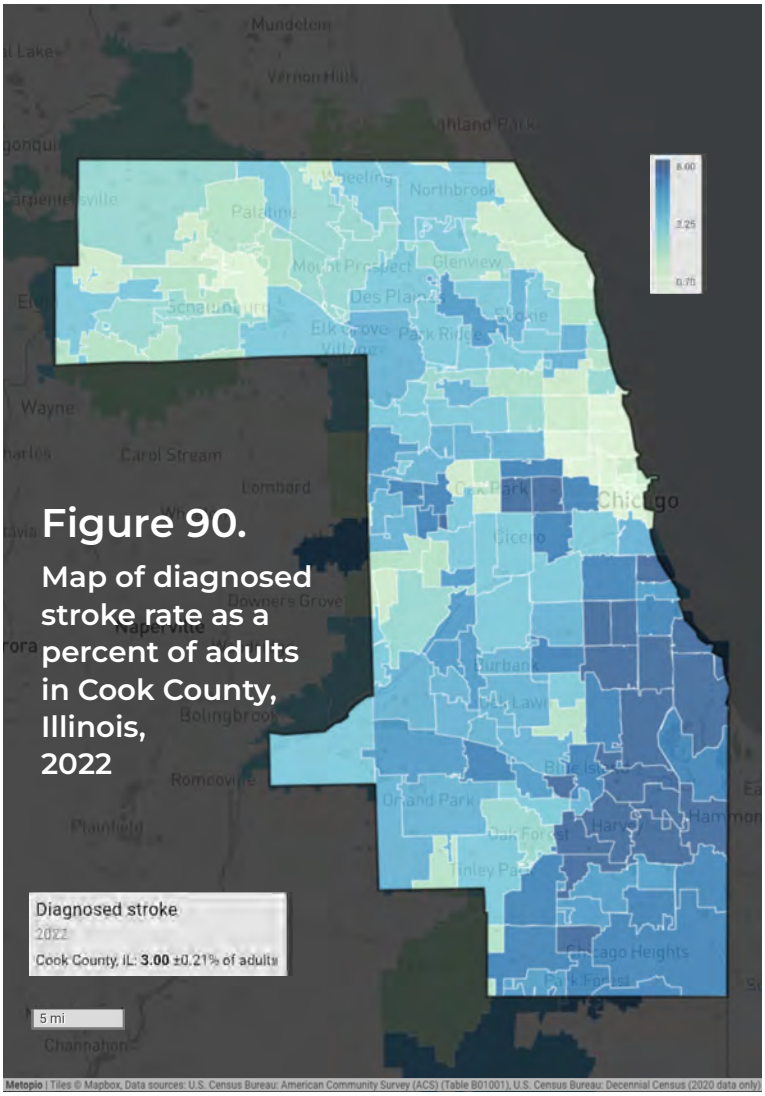


Figure 90.

Map of diagnosed stroke rate as a percent of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

After decreasing from 1999 to 2010, stroke mortality rates in Cook County began to rise again in 2013, peaking in 2020 (Centers for Disease Control and Prevention, 2022c). The mortality rate in 2022 was 50.1 per 100,000 population (Figure 91). This is higher than the rate for Illinois (41.4) and the United States (39.5) (Figure 91) which have not risen as much since the 2010s (Centers for Disease Control and Prevention, 2022c). In Cook County, stroke mortality rates are highest among Non-Hispanic Blacks followed by non-Hispanic whites (Figure 92).

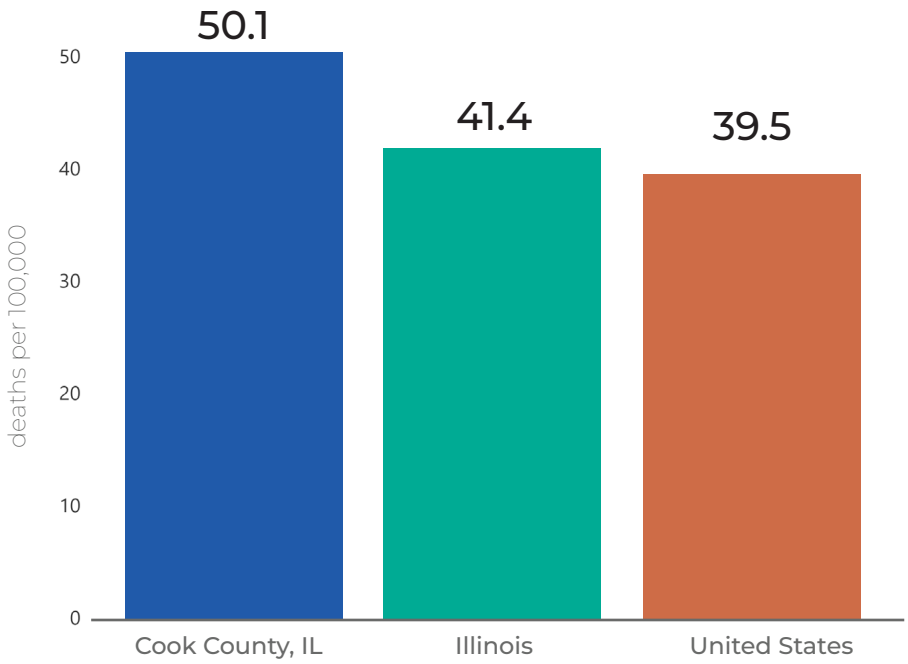


Figure 91.

Chart of stroke mortality rate per 100,000 population in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

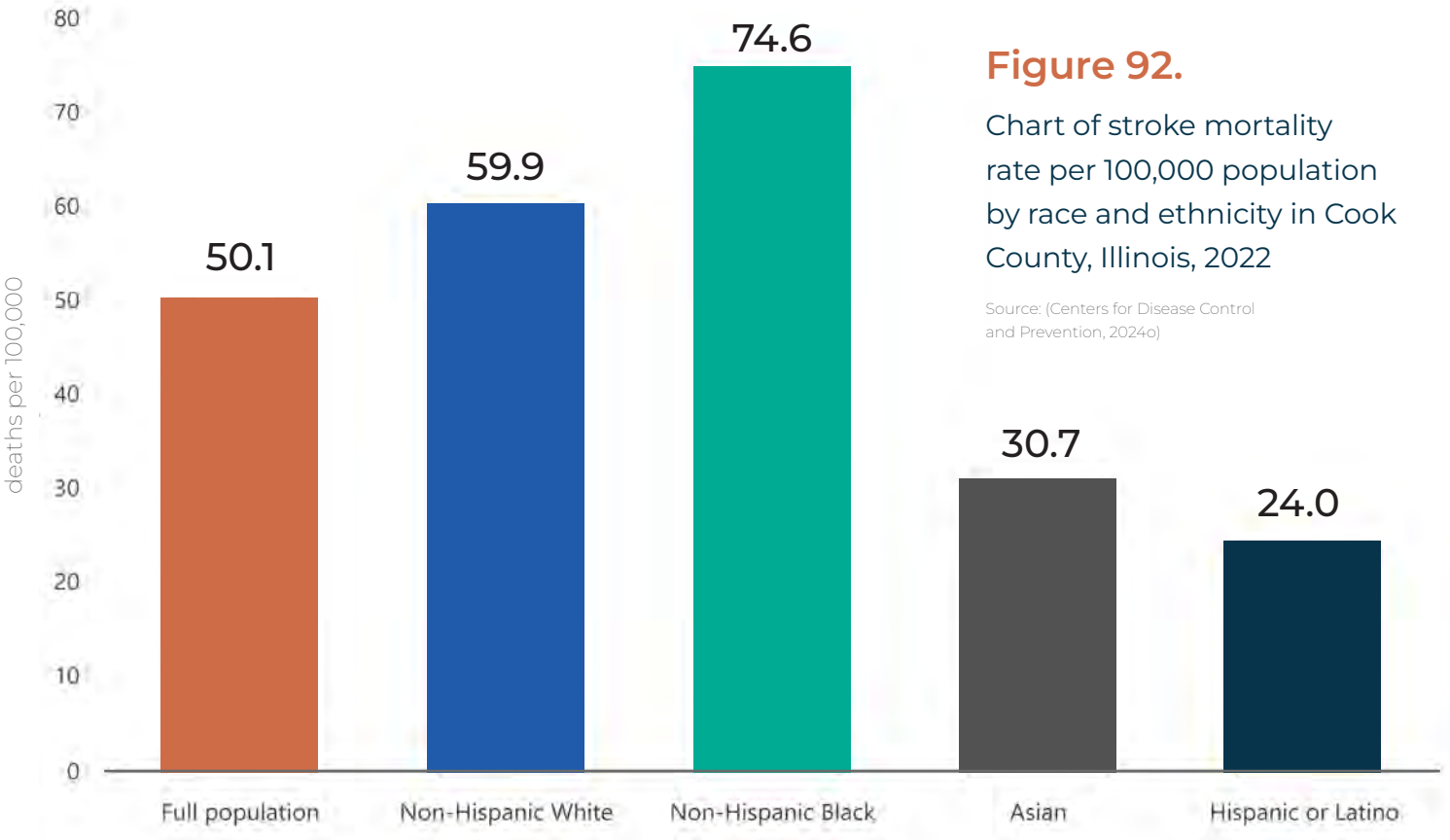


Figure 92.

Chart of stroke mortality rate per 100,000 population by race and ethnicity in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024o)

RESPIRATORY CONDITIONS

The risk for respiratory conditions such as chronic obstructive pulmonary disease (COPD) and asthma is increased by air pollution, tobacco smoke, substandard housing conditions, and frequent lower respiratory infections during childhood. These conditions increase the chance of complications and severe illness with viral infections such as influenza and COVID-19. While not curable, chronic respiratory conditions can be managed with medications and lifestyle changes (World Health Organization, 2024a). Non-Hispanic Black adults and children in the United States have the highest rates of mortality, hospitalizations, and emergency department visits compared to all other racial groups (Figure 93).

Figure 93. How does asthma affect Non-Hispanic Black populations in the United States?

- From 2018-2020, 4.0 million Non-Hispanic Blacks (adults and children) reported that they currently have asthma.
- Non-Hispanic Blacks were 30 percent more likely to have asthma than
- non-Hispanic whites, in 2019.
- In 2020, Non-Hispanic Blacks were almost three times more likely to die from asthma related causes than the non-Hispanic white population.
- In 2020, Non-Hispanic Black children had a death rate 7.6 times that of non-Hispanic white children.
- Non-Hispanic Black children were 4.5 times more likely to be admitted to the hospital for asthma, as compared to non-Hispanic white children, in 2019.

Source: (U.S. Department of Health and Human Services, Office of Minority Health, 2023)

Asthma

Adult asthma rates in Cook County are comparable to Illinois and slightly lower than in the United States (Figure 94). Rates are highest among adults on the South and West Sides of Chicago and in the south suburbs (Figure 95). The youth asthma rate for Illinois (7.0%) is slightly lower than for the United States (8.3%) (Figure 96).

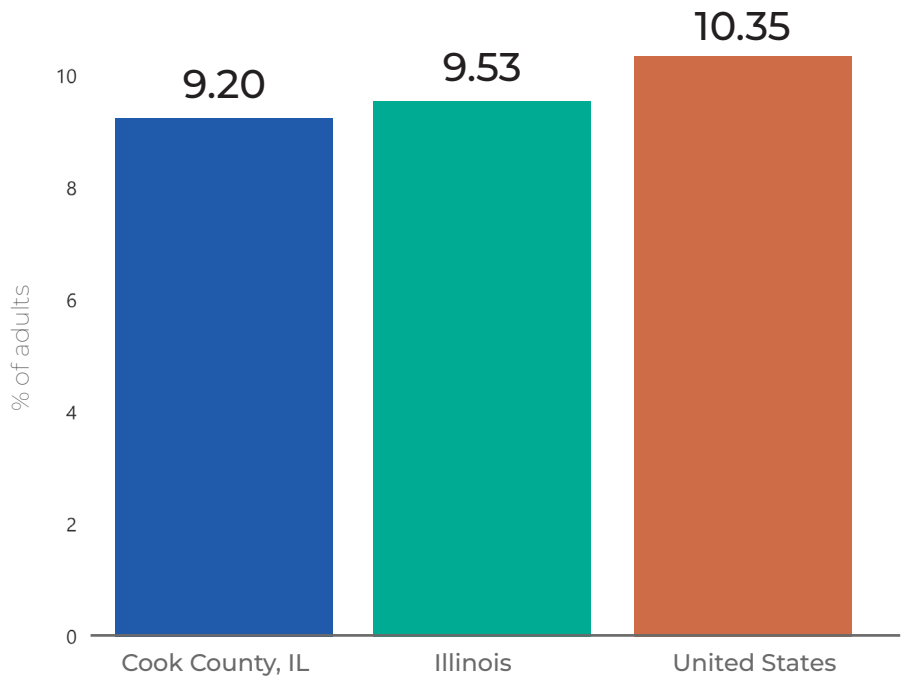


Figure 94.

Chart of percent of adults with current asthma in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

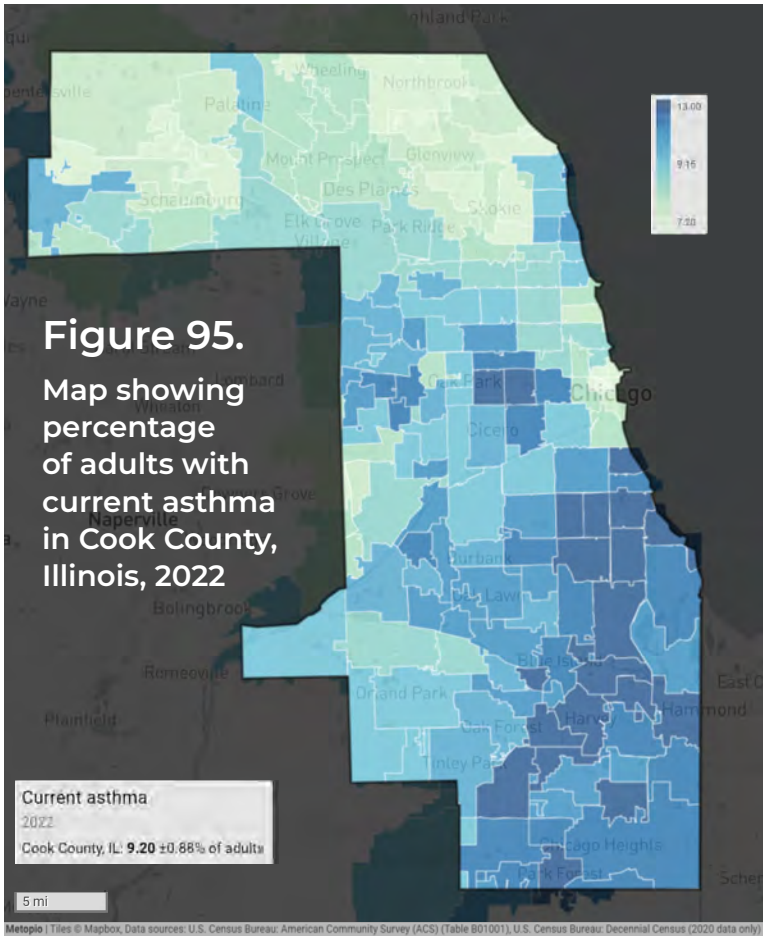


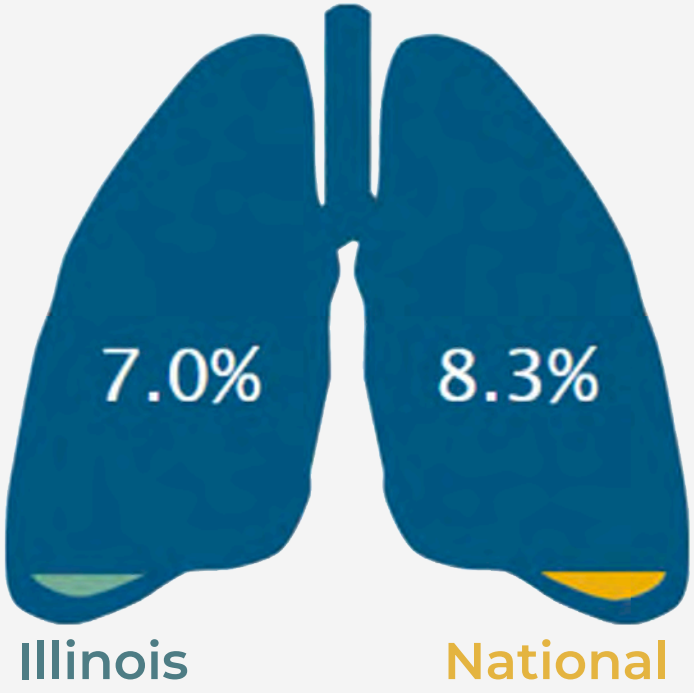
Figure 95.

Map showing percentage of adults with current asthma in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

Figure 96.

Percentage of youth with asthma in Illinois and the United States, 2021



Source: (Centers for Disease Control and Prevention, 2021)

In Cook County, as in the rest of the nation, asthma-related emergency department visits are highest among the African American/Black population. Rates for African American/Black adults are nearly 13 times higher, and for African American/Black youth, more than 6 times higher than those for white residents (Figure 97). Emergency department visit rates for Hispanic/Latine residents were also elevated compared to white residents (Figure 97).

Figure 97.

Table of emergency department visit rate per 10,000 population in Cook County, Illinois, 2022

	ADULT ASTHMA-RELATED EMERGENCY DEPARTMENT VISIT RATE (PER 10,000 POPULATION)	YOUTH ASTHMA-RELATED EMERGENCY DEPARTMENT VISIT RATE (PER 10,000 POPULATION)
Illinois	25.7	41.7
Cook County	31.1	53.9
African American/Black	97.1	133.1
Hispanic/Latine	22.4	53.1
White	7.5	19.8

Source: (Illinois Department of Public Health, 2024d)

Focus group participants frequently shared personal or family experiences with asthma. It was described as a significant health concern, particularly for children. In Humboldt Park, residents noted a family history of asthma and later realized it was linked to poor environmental conditions, including high air pollution in their neighborhood. On the South Side of Chicago, a participant described needing to take a family member to the hospital for asthma treatment but feeling unwelcome due to hospital staff's dismissive attitudes. Others shared similar experiences of discomfort in healthcare settings (unrelated to asthma) highlighting the importance of creating a welcoming environment to ensure patients feel supported and receive proper care.

Chronic Lower Respiratory Disease and Chronic Obstructive Pulmonary Disease

Chronic Lower Respiratory Disease (CLRD) is a group of conditions that affect lungs and airways. Types of CLRD include asthma, chronic bronchitis, emphysema, and Chronic Obstructive Pulmonary Disease (COPD). COPD is caused by lung damage that narrows airways and reduces airflow making it difficult to breathe. Risks for COPD include exposure to cigarette smoke, hazardous workplace exposures, asthma, age, childhood respiratory infections, genetics, air pollution, poor indoor air quality, and stress. COPD prevalence in Cook County is slightly lower than that for the United States overall (Figure 98). Like asthma, COPD prevalence is highest in the west and south regions (Figure 99).

While the overall mortality rate in Cook County for chronic lower respiratory diseases is lower than the national average, it remains higher than average among Non-Hispanic Black and non-Hispanic white individuals (Figure 100 and Figure 101).

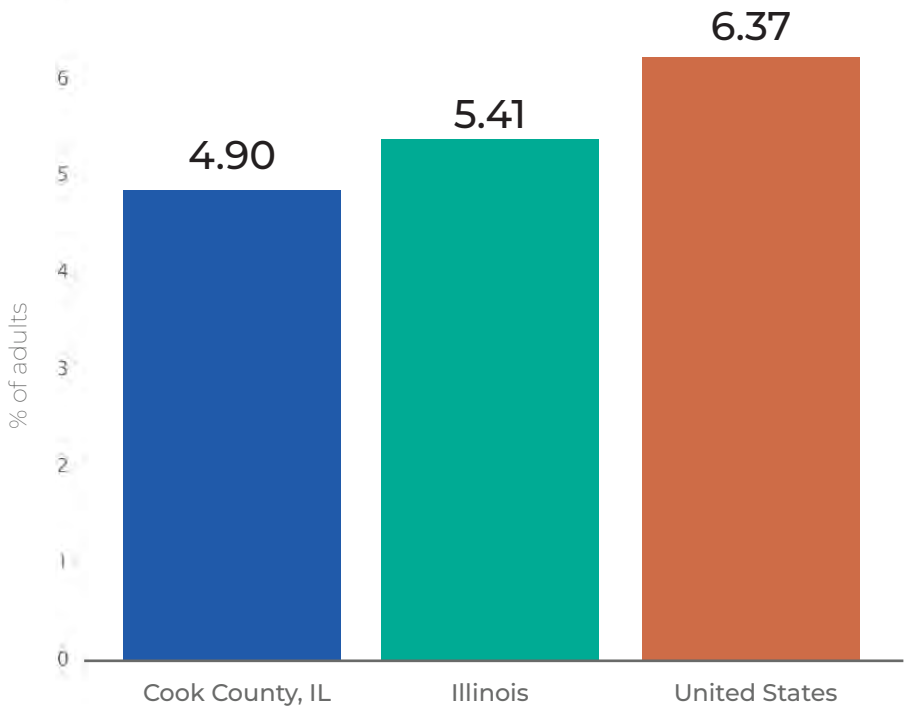


Figure 98.

Chart of diagnosed chronic obstructive pulmonary disease rate as a percent of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

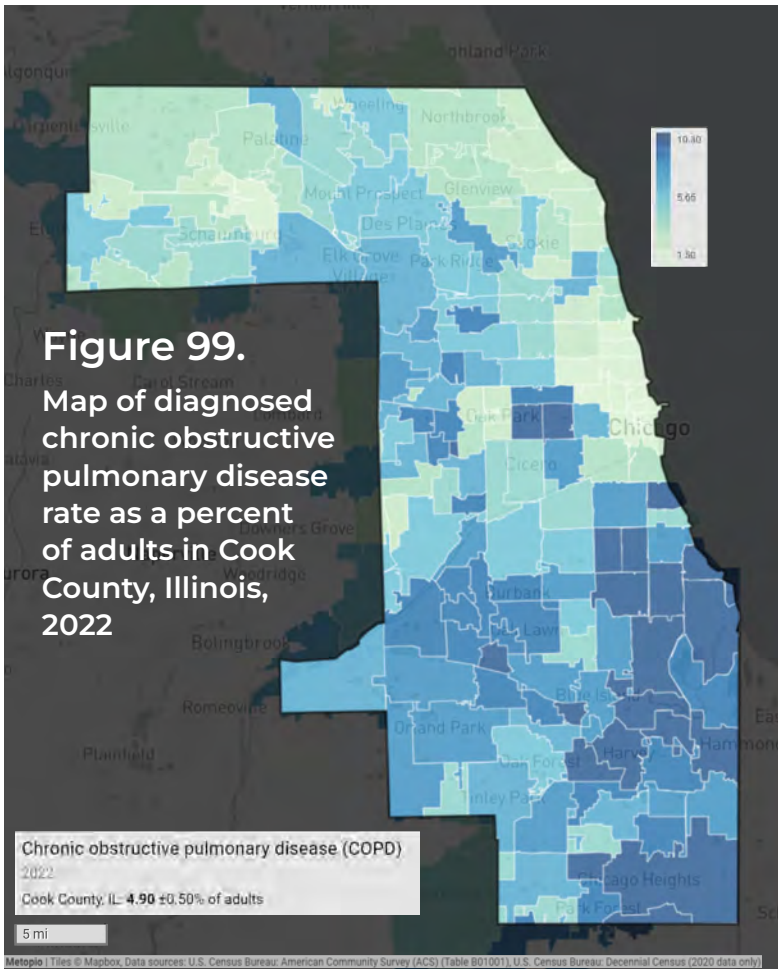


Figure 99.

Map of diagnosed chronic obstructive pulmonary disease rate as a percent of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

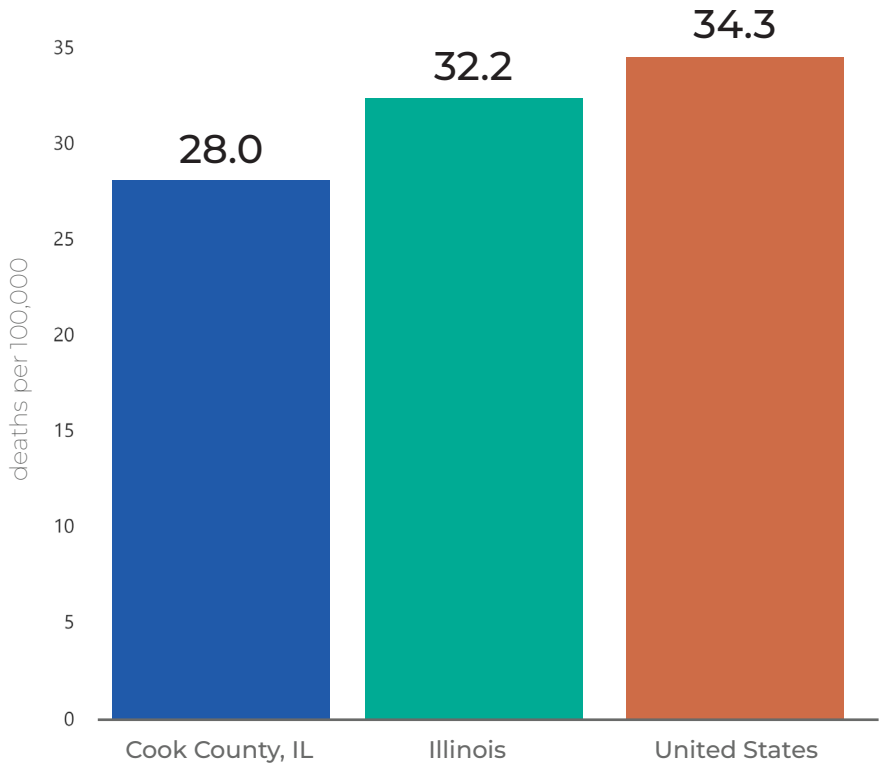


Figure 100.

Chart of chronic lower respiratory disease mortality rate per 100,000 population in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

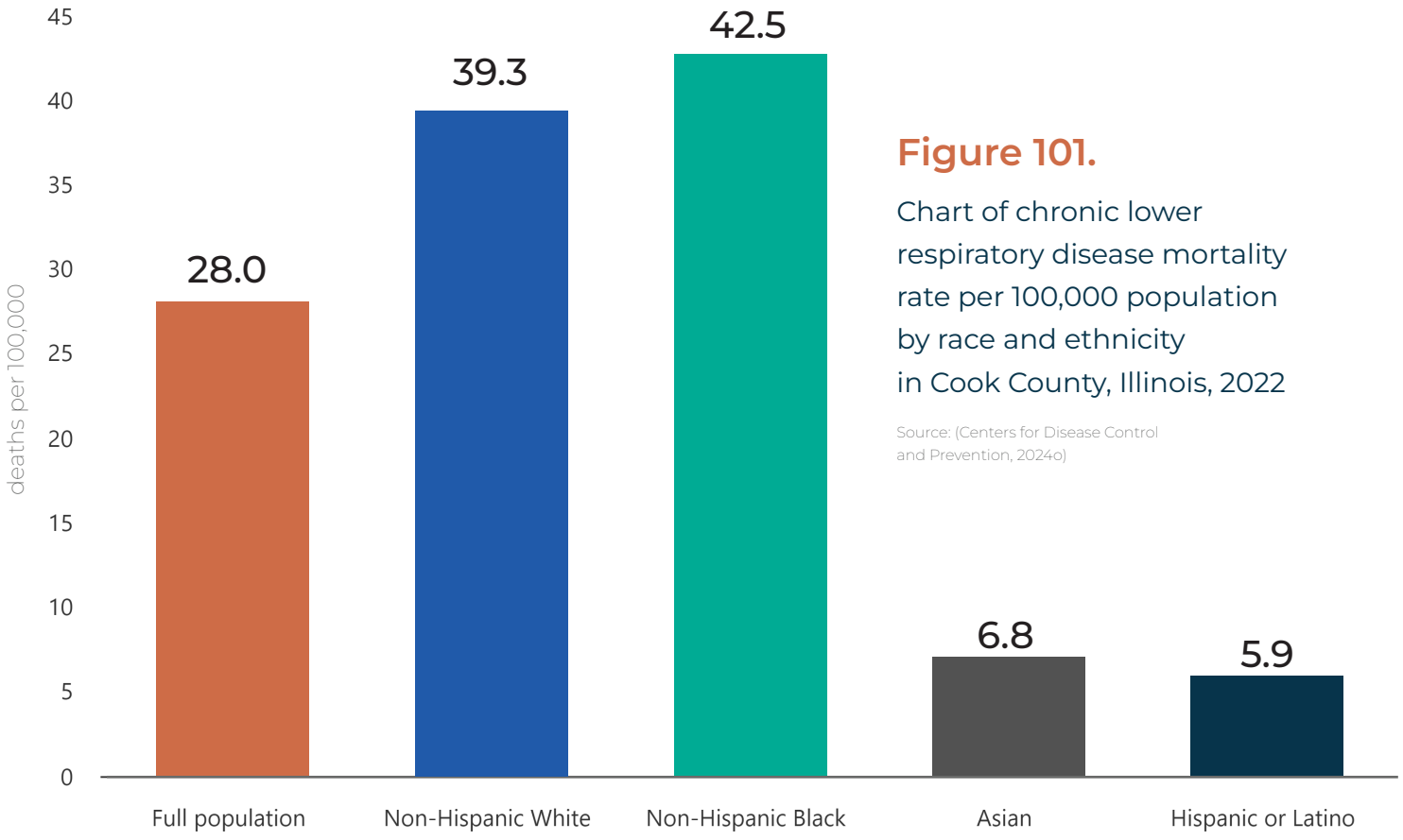


Figure 101.

Chart of chronic lower respiratory disease mortality rate per 100,000 population by race and ethnicity in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024o)

Three percent of community input survey respondents rated lung disease as a top health issue in their community (Figure 73). Respiratory-related needs such as clean air, parks and recreational spaces, and access to quality pediatric care were also selected as top community health needs (Figure 102). Eighteen percent of respondents disagreed or strongly disagreed with the statement "my community has clean air and water" (Figure 103).

Figure 102.

Percent of community input survey respondents who rated respiratory condition-related needs among the top three health needs in their community (n=1782)

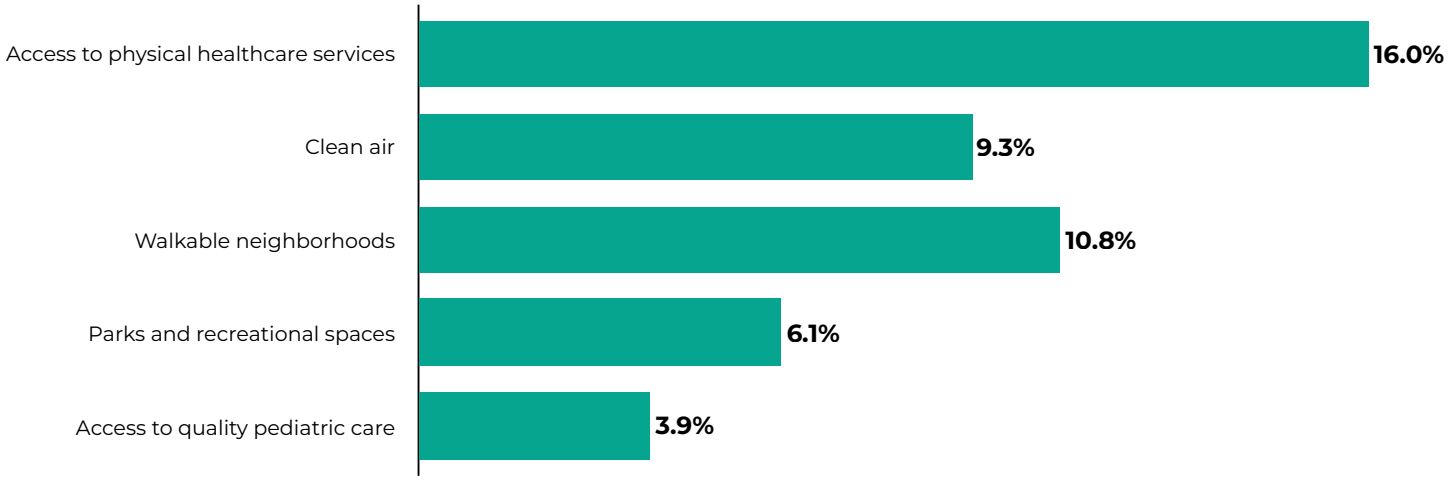
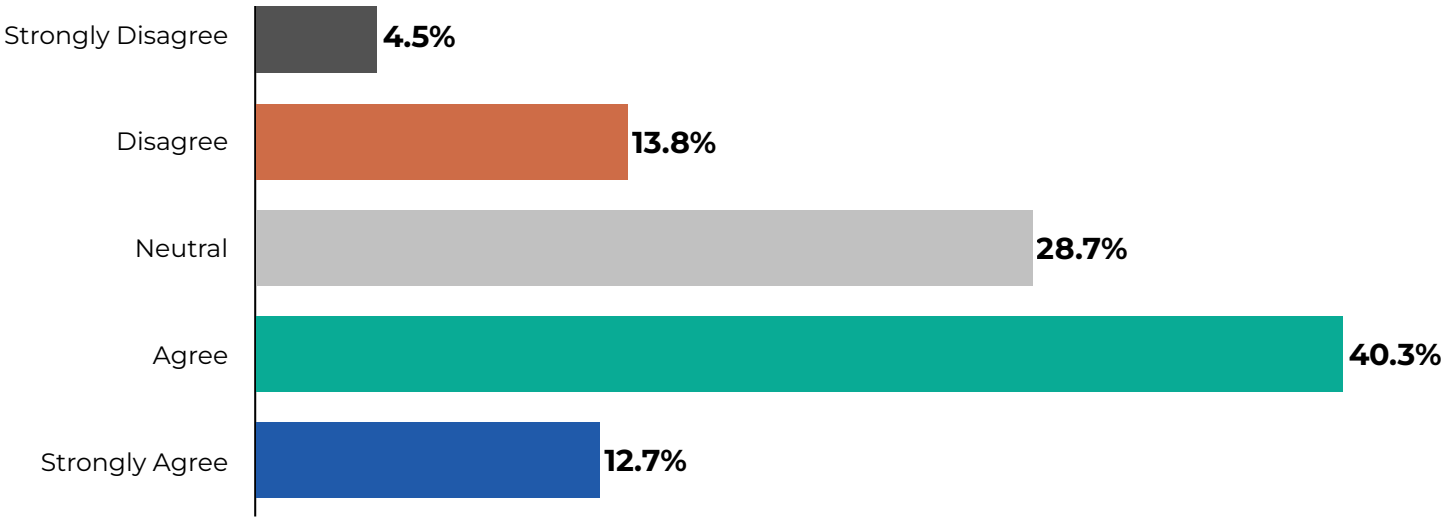


Figure 103.

Survey responses – Agreement with the statement "My community has clean air and water." (n=1847)



CANCER

Cancer is a leading cause of death in the United States. Breast, lung, colorectal (colon), and prostate cancer are some of the most common cancers. In the United States, most cancer death rates have been declining over the last 30 years, but the cost for cancer care is still high at $208.9 billion in 2020 (National Institutes of Health, National Cancer Institute, 2024). Cancer develops from DNA changes influenced by factors like genetics, lifestyle, and social determinants of health. Black/African American individuals have the highest cancer rates, driven by systemic and institutional racism, which creates disparities in research, access to care, poverty, stress, and the built environment (National Institutes of Health, National Cancer Institute, 2024).

New screening methods have helped lower mortality rates by detecting cancer earlier which can increase the effectiveness of treatment. Mammograms, colonoscopies, exams, and blood tests are common forms of cancer screening (National Institutes of Health, National Cancer Institute, 2024). However, disparities in access to this type of testing increase disparities in cancer treatment and outcomes. Other examples of cancer inequities are described in Figure 104.

Figure 104.

Examples of cancer inequities in the United States, 2024

- Black/African American people have higher death rates than all other racial and ethnic groups for many, although not all, cancer types.
- Despite having slightly lower incidence rates of breast cancer than those of white women, Black/African American women are more likely than white women to die of the disease.
- Although deaths from prostate cancer have dropped substantially in recent decades among all men, Black/African American men are more than twice as likely as white men to die of prostate cancer and continue to have the highest prostate cancer mortality rates among all racial and ethnic groups in the United States.
- People with more education are less likely to die prematurely (before the age of 65) from colorectal cancer than those with less education, regardless of race or ethnicity.
- Hispanic/Latine, Black/African American, and American Indian/Alaska Native women have higher incidence rates of cervical cancer than women of other racial and ethnic groups, with Black/African American women having the highest rates of death from the disease.
- American Indians/Alaska Natives have higher death rates from kidney cancer than any other racial and ethnic group.
- The rates of smoking and alcohol drinking, which increase cancer risk, are higher among lesbian, gay, and bisexual youths than among heterosexual youths.
- American Indians/Alaska Natives have the highest incidence and mortality rates of liver and intrahepatic bile duct cancer, followed by Hispanic/Latinae individuals and Asians/Pacific Islanders.

Source: (National Institutes of Health, National Cancer Institute, 2024)

Cancer disparities arise from a complex mix of social determinants of health, behavior, biology, and genetics, all of which affect cancer risk and outcomes (National Institutes of Health, National Cancer Institute, 2024). Certain groups face greater barriers to healthcare, including those who are characterized as low income, have low health literacy, must travel long distances, lack health insurance, or have limited access to transportation and medical leave (National Institutes of Health, National Cancer Institute, 2024). These barriers reduce access to cancer screenings and guideline-based treatments, often leading to late-stage diagnoses that are harder to treat.

Environmental factors also contribute to disparities. Communities lacking clean air or water may face exposure to cancer-causing substances, and neighborhoods without affordable healthy foods or safe spaces for exercise increase risks of poor diet, physical inactivity, obesity, and cancer (National Institutes of Health, National Cancer Institute, 2024).

Even individuals with higher socioeconomic status or health insurance can experience cancer disparities due to institutional racism, chronic stress, biases in healthcare, mistrust of the system, or fatalistic views about cancer (National Institutes of Health, National Cancer Institute, 2024). Addressing these disparities requires tackling the underlying systemic and environmental factors driving them.

Ten percent of community input survey respondents selected cancer as one of the top three health issues in their community, making it the eleventh ranked health need overall (Figure 73). Respondents rated several cancer related health needs as top priorities including clean air, safe water, easy access to public transportation, safety and low crime, parks and recreational spaces, and the ability to access physical healthcare services within a reasonable amount of time.

Focus group participants raised concerns about limited access to cancer screening and treatment services and highlighted the importance of education on early detection and prevention. Some

Cook County residents appreciated community health fairs that offered cancer screenings, increasing accessibility and awareness of symptoms. However, many of these events stopped during COVID-19 and have not resumed, making screenings less accessible. Restoring health fairs and local events could improve access to screenings and help build trust between hospitals and the community.

Figure 105.

Table of breast cancer incidence per 100,000 population in Cook County, Illinois, 2017-2021

	COOK COUNTY BREAST CANCER INCIDENCE PER 100,000 POPULATION	ILLINOIS BREAST CANCER INCIDENCE PER 100,000 POPULATION	UNITED STATES BREAST CANCER INCIDENCE PER 100,000 POPULATION
All population	130.7	133.6	129.8
Non-Hispanic white	143.7	139.8	135.7
Non-Hispanic Black	133.5	133.7	128.8
AI/AN	Not available	Not available	108.5
API	106.2	106.6	105.1
Hispanic	96.3	101.6	101.0

Source: (National Cancer Institute, 2025)

In 2022, breast cancer mortality rates in Cook County were higher than in Illinois and the U.S., with the highest rates among non-Hispanic Black and non-Hispanic white individuals (Figure 106). Although rates had been declining since 1999, they spiked in 2019. While state and national rates have since dropped, Cook County rates remain elevated (Figure 107).

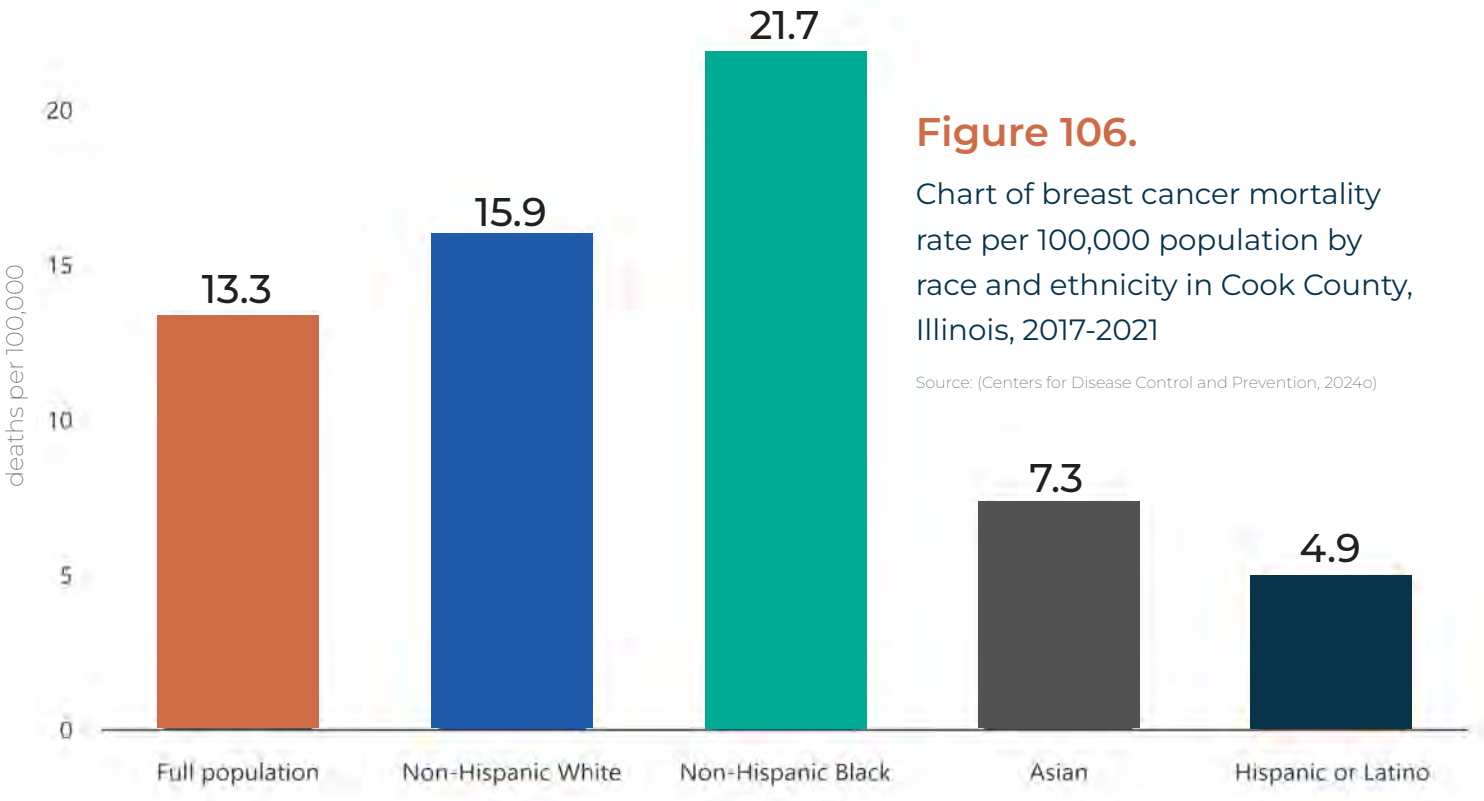


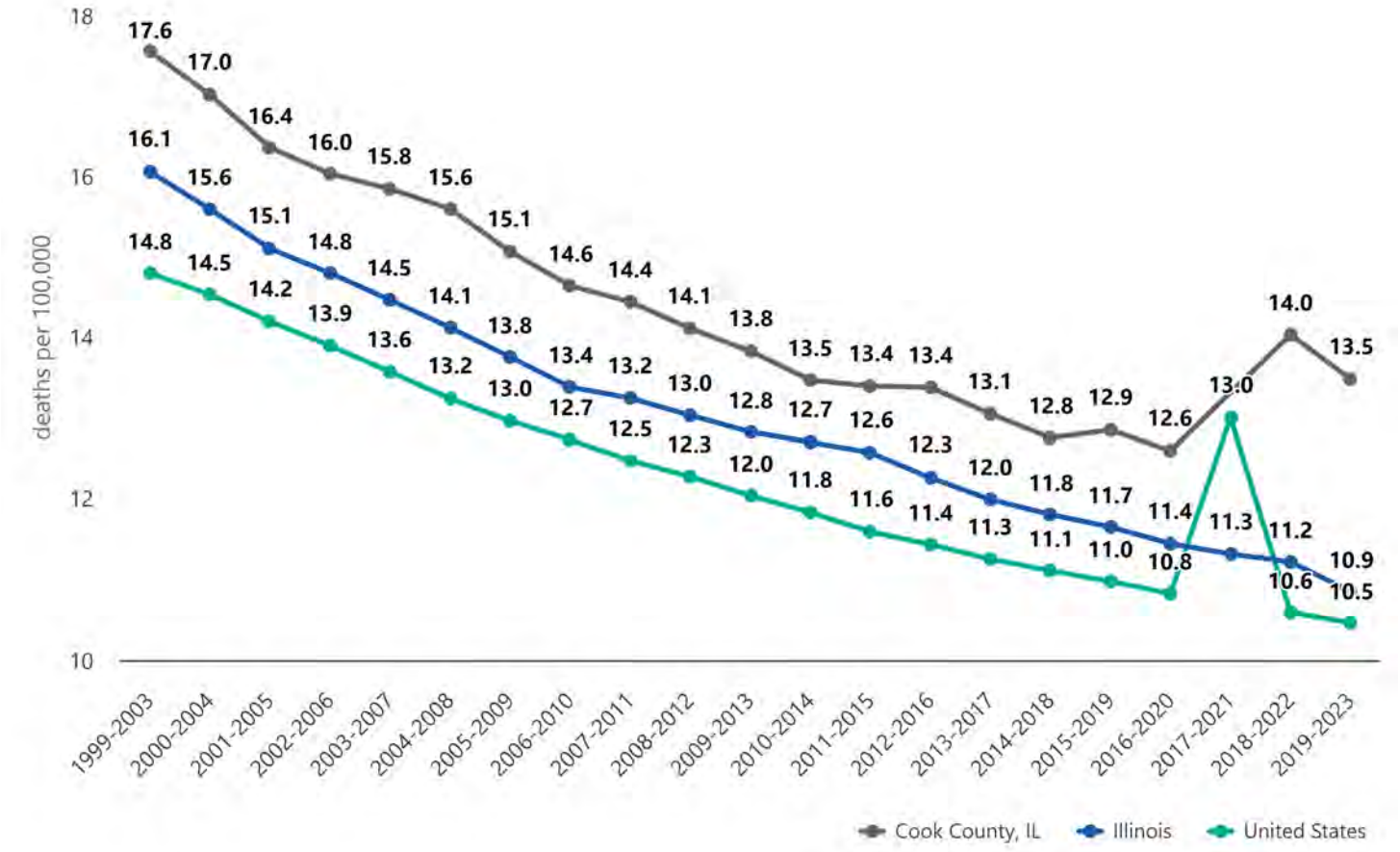
Figure 106.

Chart of breast cancer mortality rate per 100,000 population by race and ethnicity in Cook County, Illinois, 2017-2021

Source: (Centers for Disease Control and Prevention, 2024o)

Figure 107.

Chart of breast cancer mortality rate per 100,000 population over time in Cook County, Illinois, 1999-2023



Created on Metopio I metop.io/i/du826cag I Data sources: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) (Only in IL) Breast cancer mortality: Deaths per 100,000 residents due to breast cancer (ICD-10 code CS0). Includes males; stratify by females to see the female-specific rate. Source: (Centers for Disease Control and Prevention, 2024o)

Lung cancer

The lung cancer diagnosis rate for Cook County is higher than the United States diagnosis rate, but slightly lower than the diagnosis rate for Illinois (Figure 108). But diagnosis rates in Cook County have been falling since the mid-1990s, largely due to a decrease in smoking (Kim et al., 2024). Lung cancer mortality rates in Cook County are similar to those in Illinois and the United States (Centers for Disease Control and Prevention, 2024o). Historically, Non-Hispanic Black individuals in Cook County had the highest rates, but in recent years, rates for non-Hispanic white individuals have increased. By 2022, mortality rates for Non-Hispanic Black and non-Hispanic white individuals were comparable (Figure 109).

Prostate cancer

Prostate cancer diagnosis rates in Cook County are similar to Illinois but higher than the United States, with the highest rates on the South Side of Chicago and in the southern suburbs (Figure 110Figure 111). In 2022, the Cook County prostate cancer mortality rate was 23% higher than both Illinois and the United States (Figure 112). While overall mortality rates have declined, Non-Hispanic Black men in Cook County had mortality rates 40% higher than non-Hispanic white men (Figure 113).

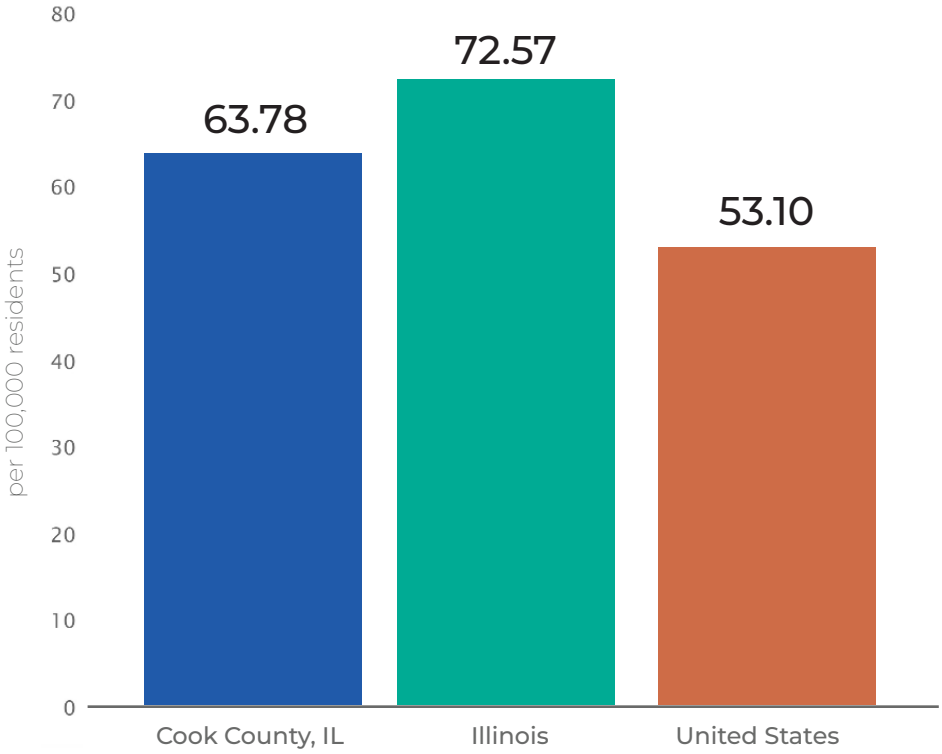


Figure 108.

Chart of lung cancer diagnoses rate per 100,000 residents in Cook County, Illinois, 2017-2021

Source: (Illinois Department of Public Health, 2021b)

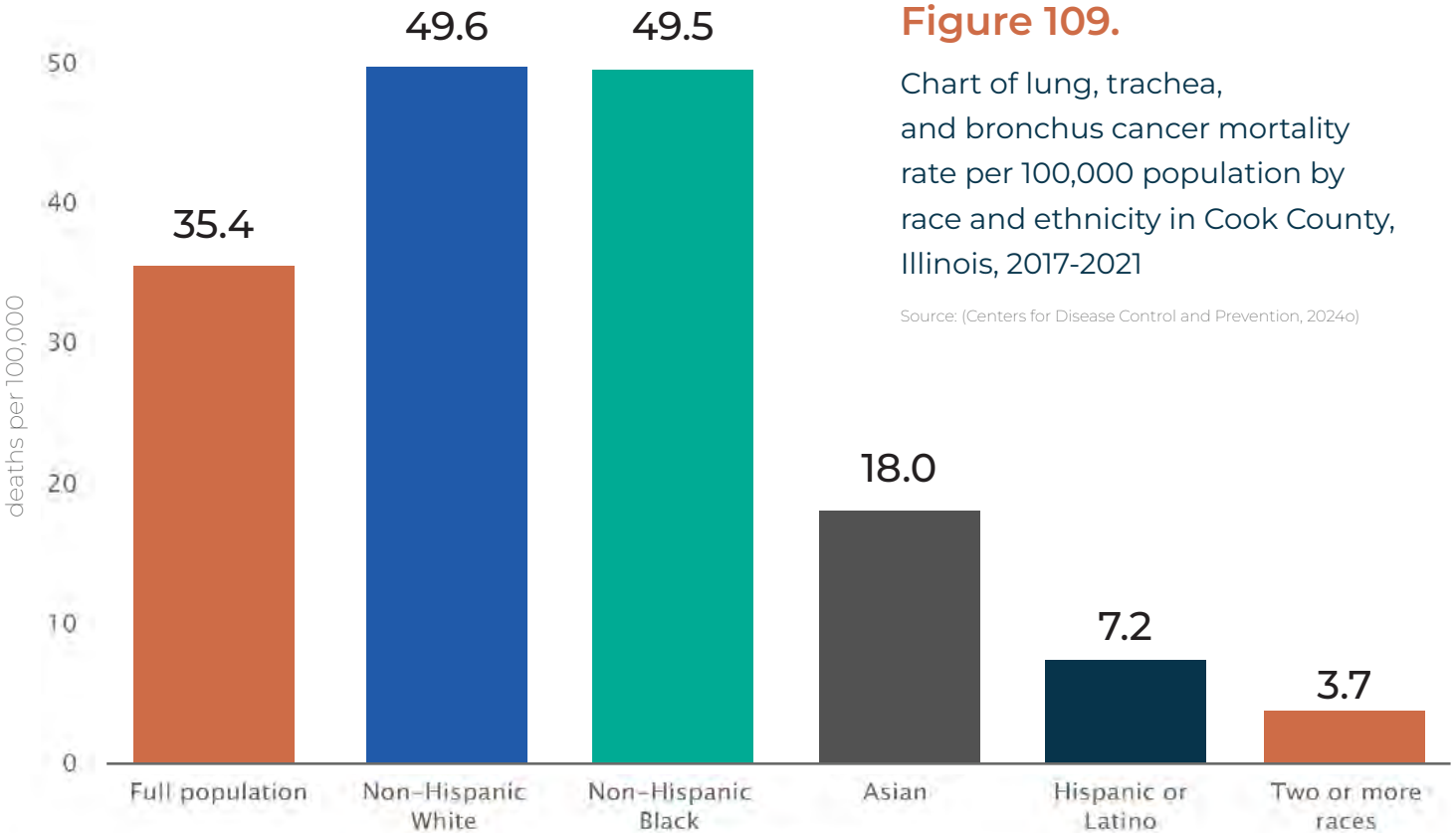


Figure 109.

Chart of lung, trachea, and bronchus cancer mortality rate per 100,000 population by race and ethnicity in Cook County, Illinois, 2017-2021

Source: (Centers for Disease Control and Prevention, 2024o)

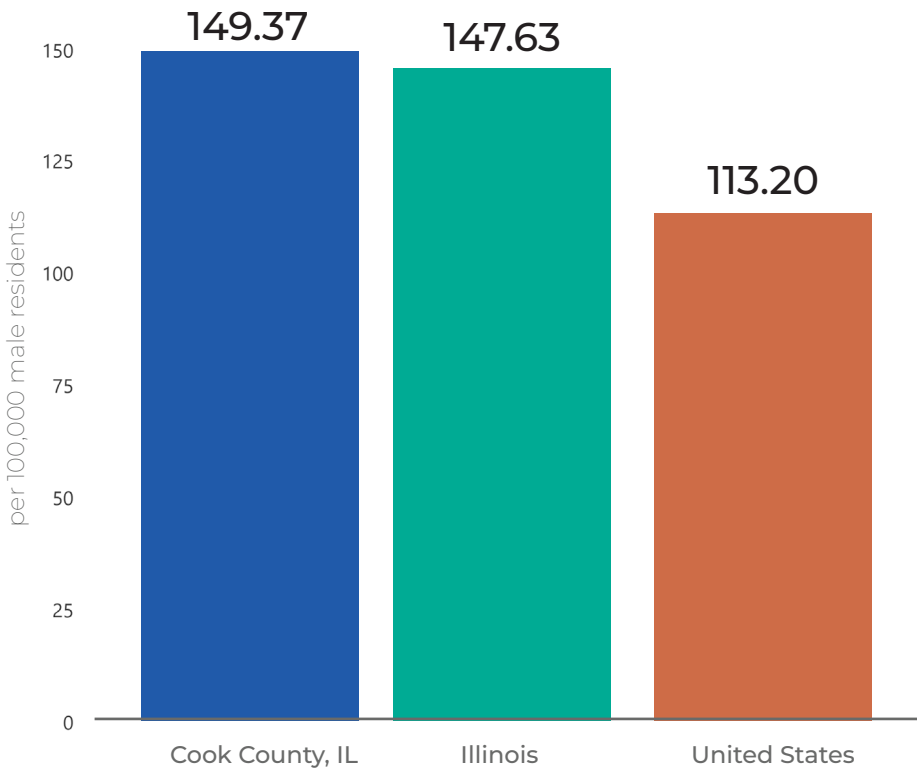


Figure 110.

Chart of prostate cancer diagnoses rate per 100,000 male residents in Cook County, Illinois, 2018-2022

Source: (Illinois Department of Public Health, 2021b)

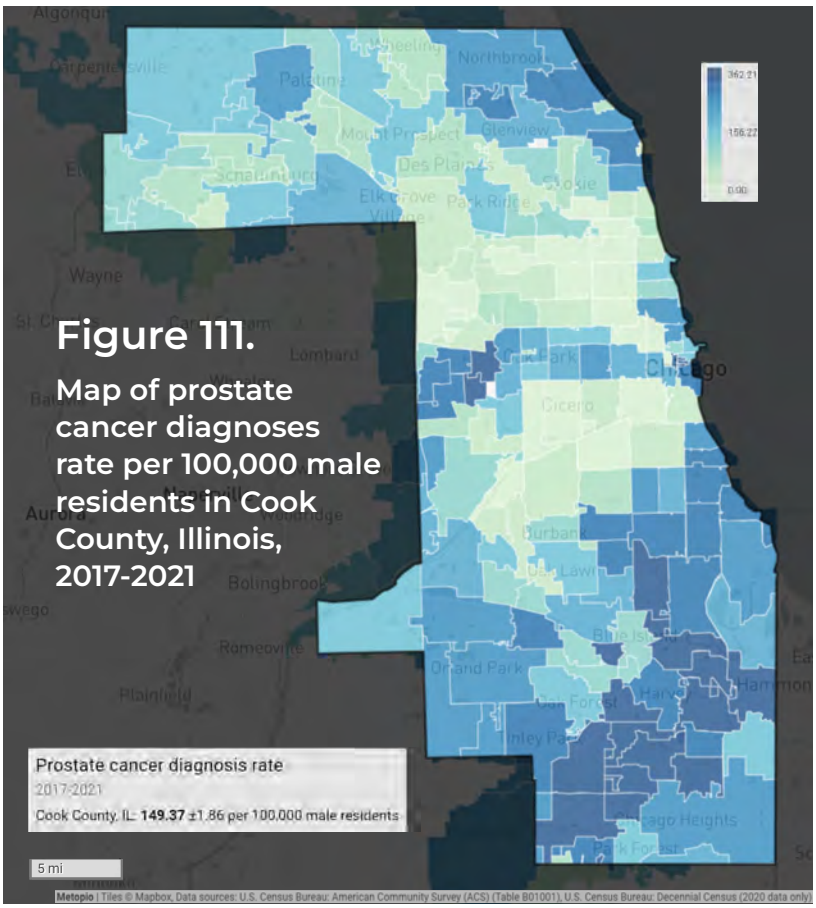


Figure 111.

Map of prostate cancer diagnoses rate per 100,000 male residents in Cook County, Illinois, 2017-2021

Source: (Centers for Disease Control and Prevention, 2024q)

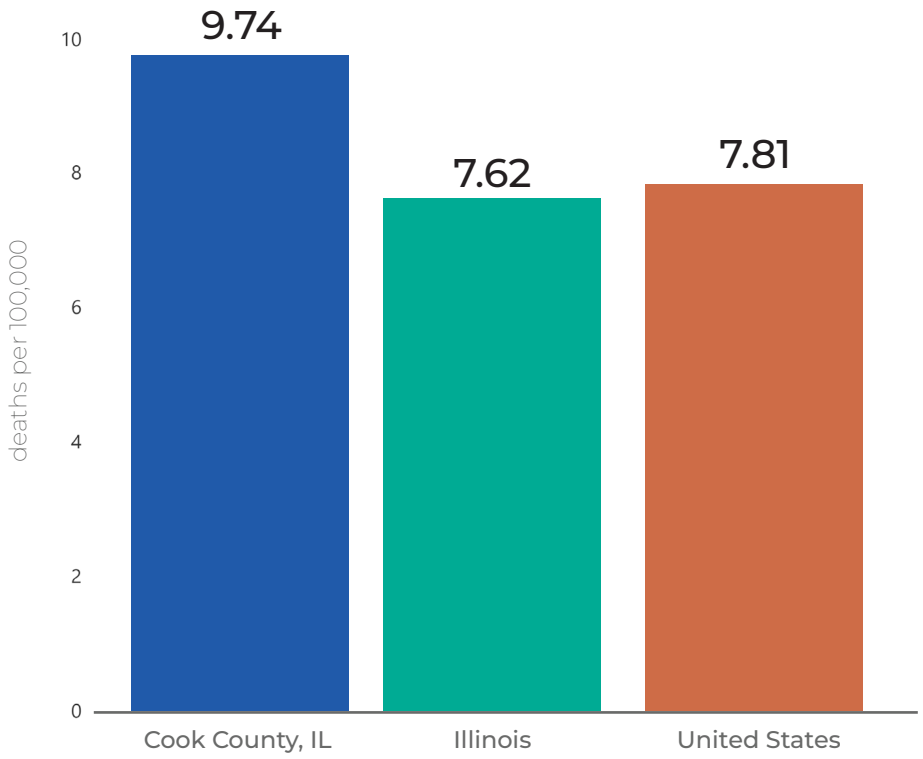


Figure 112.

Chart of prostate cancer mortality rate per 100,000 residents in Cook County, Illinois, 2018-2022

Source: (Centers for Disease Control and Prevention, 2024o)

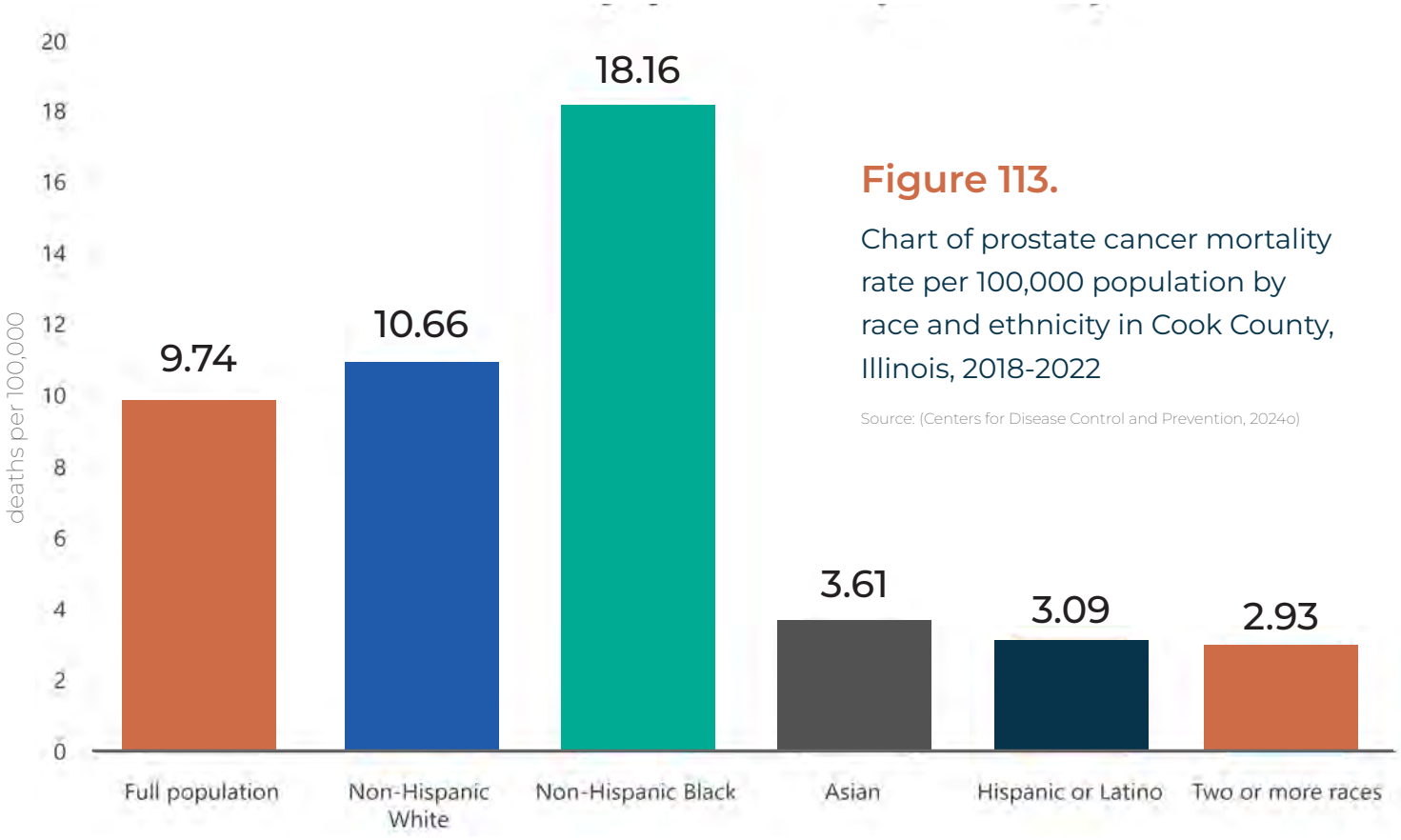


Figure 113.

Chart of prostate cancer mortality rate per 100,000 population by race and ethnicity in Cook County, Illinois, 2018-2022

Source: (Centers for Disease Control and Prevention, 2024o)

Colon cancer

Colon cancer diagnosis rates in Cook County have decreased by 26% since 2002 (Illinois Department of Public Health, Illinois State Cancer Registry, 1998-2021). In 2021, diagnosis rates in Cook County matched those in Illinois but were higher than diagnosis rates in the United States. Rates were highest on the South Side of Chicagoand in the southern suburbs (Figure 114 and Figure 115). In 2022, the Cook County mortality rates surpassed both Illinois and the United States, driven by an increase between 2020 to 2022 (Figure 116). Non-Hispanic Black individuals in Cook County experienced colon cancer mortality rates 40% higher than non-Hispanic white individuals (Figure 117).

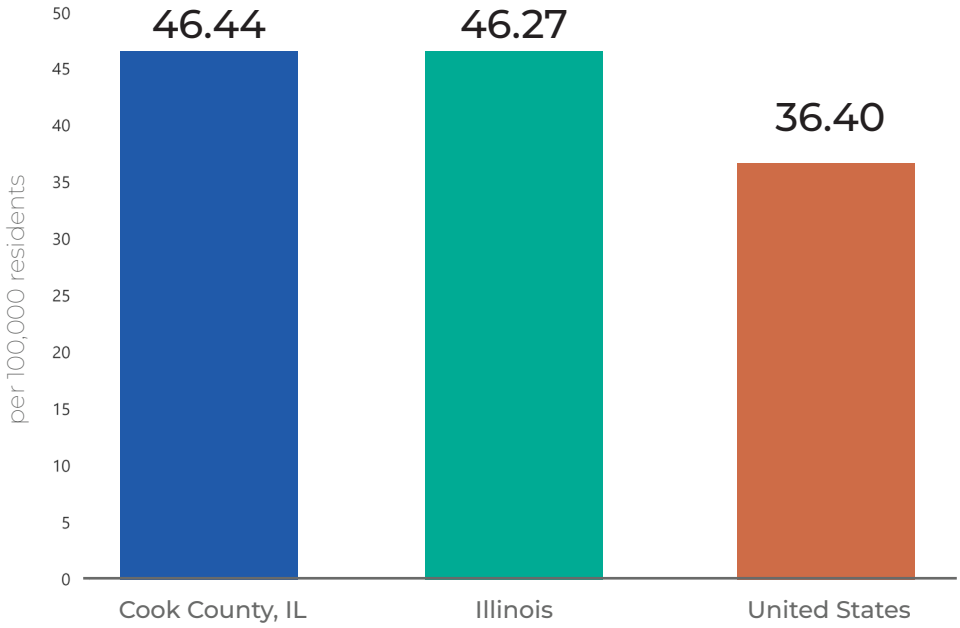


Figure 114.

Chart of colon cancer diagnoses rate per 100,000 residents in Cook County, Illinois, 2017-2021

Source: (Centers for Disease Control and Prevention, 2024o)

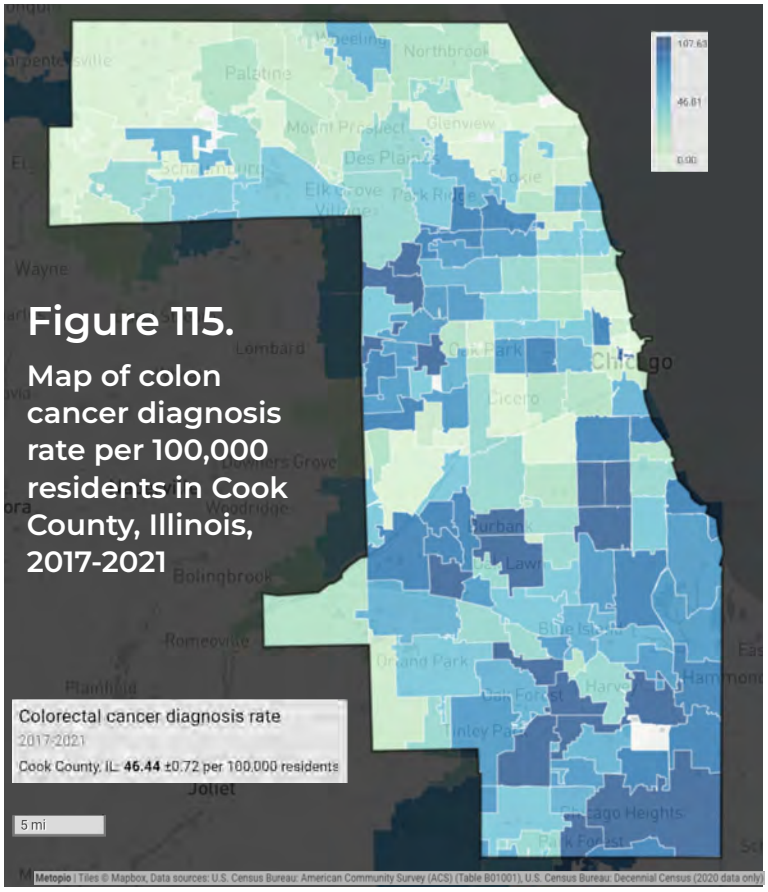


Figure 115.

Map of colon cancer diagnosis rate per 100,000 residents in Cook County, Illinois, 2017-2021

Source: (Illinois Department of Public Health, 2021b)

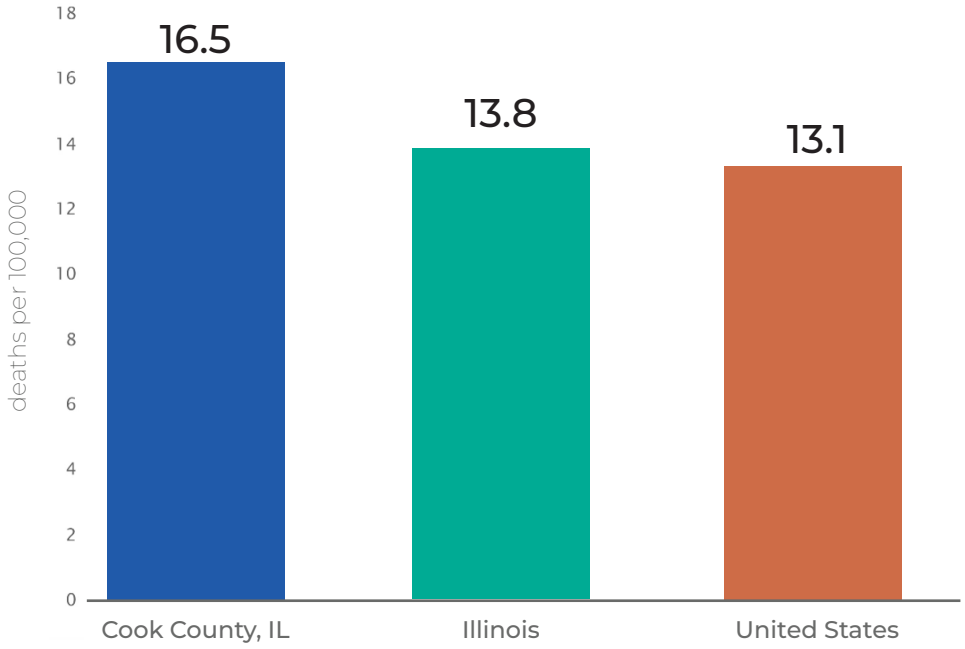


Figure 116.

Chart of colon cancer mortality rate per 100,000 population in Cook County, Illinois, 2018-2022

Source: (Centers for Disease Control and Prevention, 2024o)

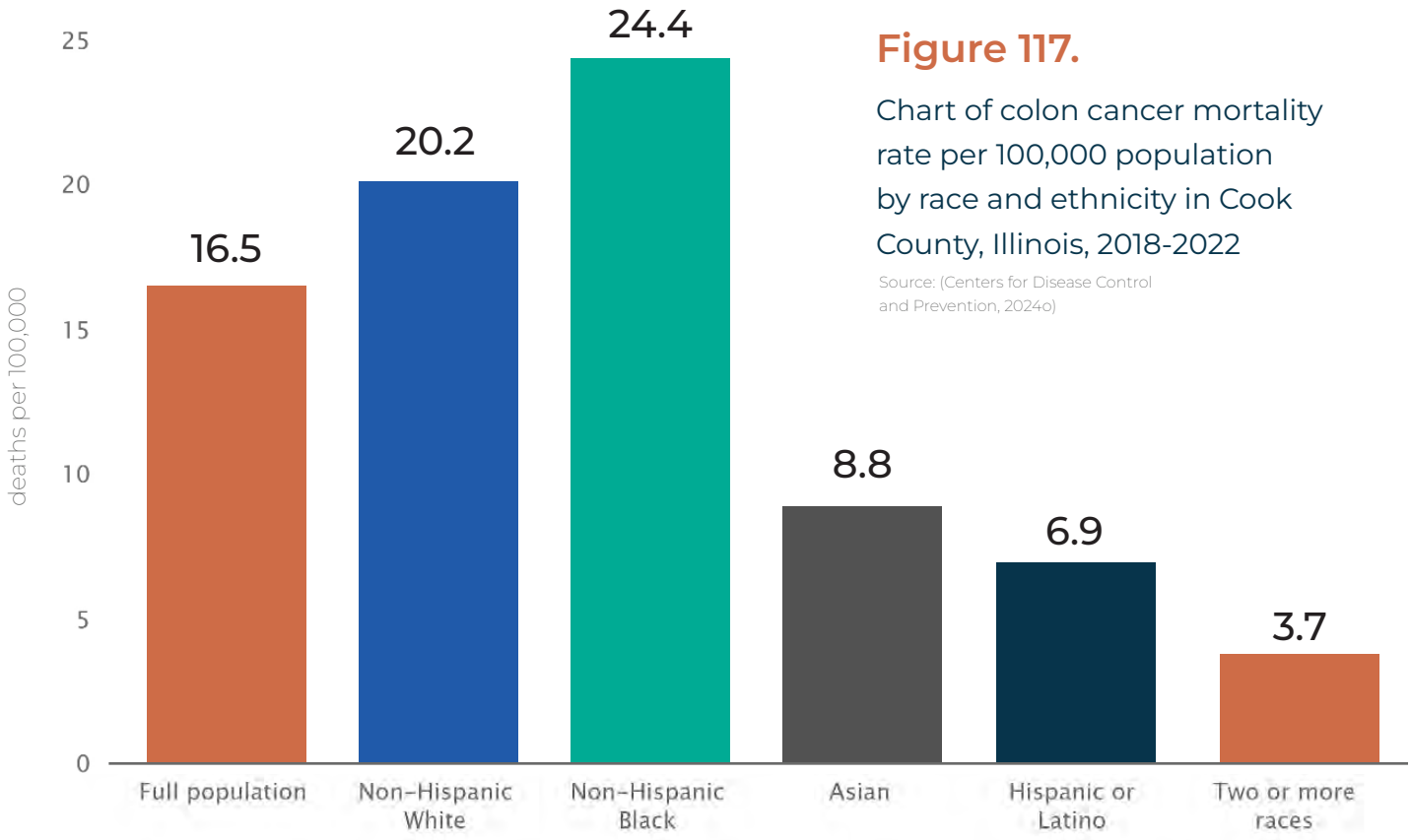


Figure 117.

Chart of colon cancer mortality rate per 100,000 population by race and ethnicity in Cook County, Illinois, 2018-2022

Source: (Centers for Disease Control and Prevention, 2024o)

ALZHEIMER'S DISEASE AND DEMENTIA

Alzheimer's Disease is a brain disorder that impacts memory and thinking, eventually making it difficult for individuals to manage daily tasks or care for themselves. It is the most common cause of dementia in older adults. It mainly affects older adults and is the seventh leading cause of death in the United States. While its exact causes are unclear, Alzheimer's is associated with aging, genetics, lifestyle, and environmental factors. (National Institutes of Health, National Institute on Aging, 2023)

Five percent of community input survey respondents selected cognitive conditions including Alzheimer's, dementia, Parkinson's, as a top health issue in their community.

Alzheimer's Disease prevalence and mortality rates in the Medicare population in Cook County are similar to those in Illinois and the United States (Figure 118 and Figure 120). Prevalence is highest among Non-Hispanic Black individuals, while mortality rates are highest among non-Hispanic white individuals (Figure 119 and Figure 121). Between 2018 and 2020, the mortality rate for non-Hispanic whites more than doubled, while it decreased by 37% for Hispanic or Latino individuals (Centers for Disease Control and Prevention, National Vital Statistics System-Mortality, 2018-2022).

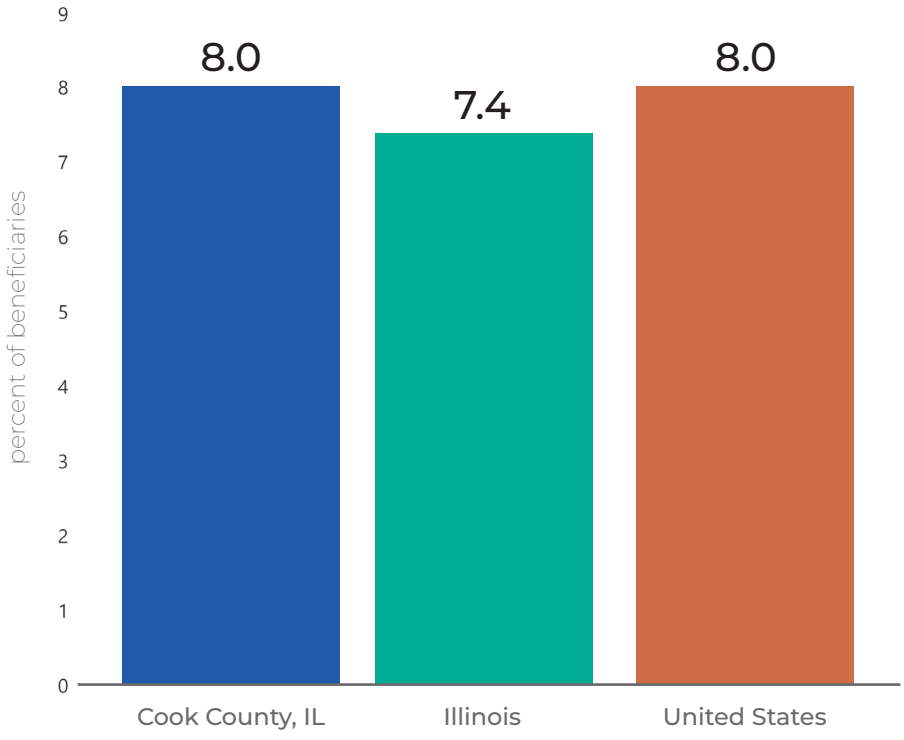


Figure 118.

Chart of Alzheimer's Disease prevalence as a percentage of Medicare beneficiaries in Cook County, Illinois, 2022

Source: (Centers for Medicare and Medicaid Services (CMS), 2024a)

Figure 119.

Chart of Alzheimer's Disease prevalence as a percentage of Medicare beneficiaries by race and ethnicity in Cook County, Illinois, 2022

Source: (Centers for Medicare and Medicaid Services (CMS), 2024a)

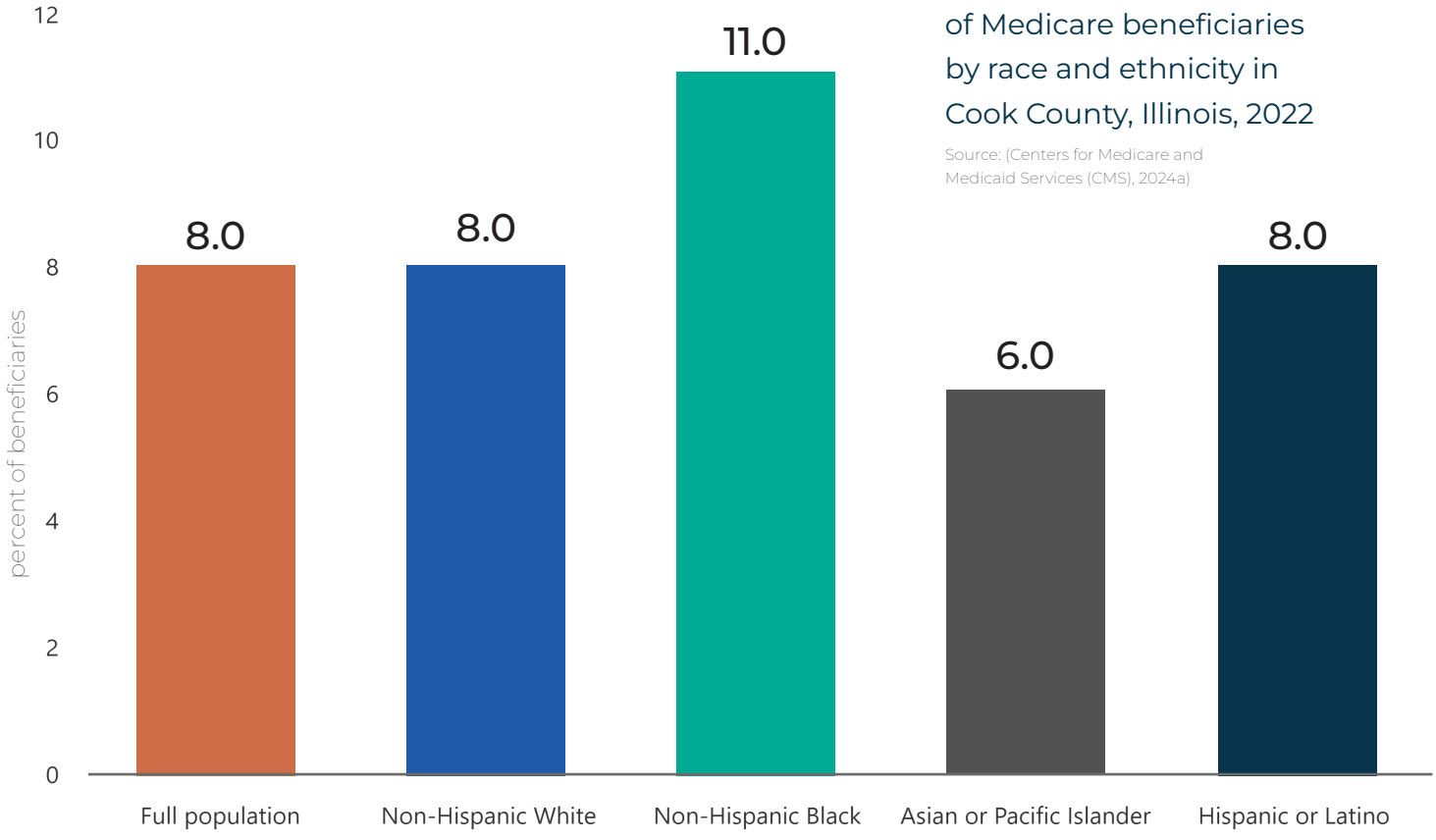
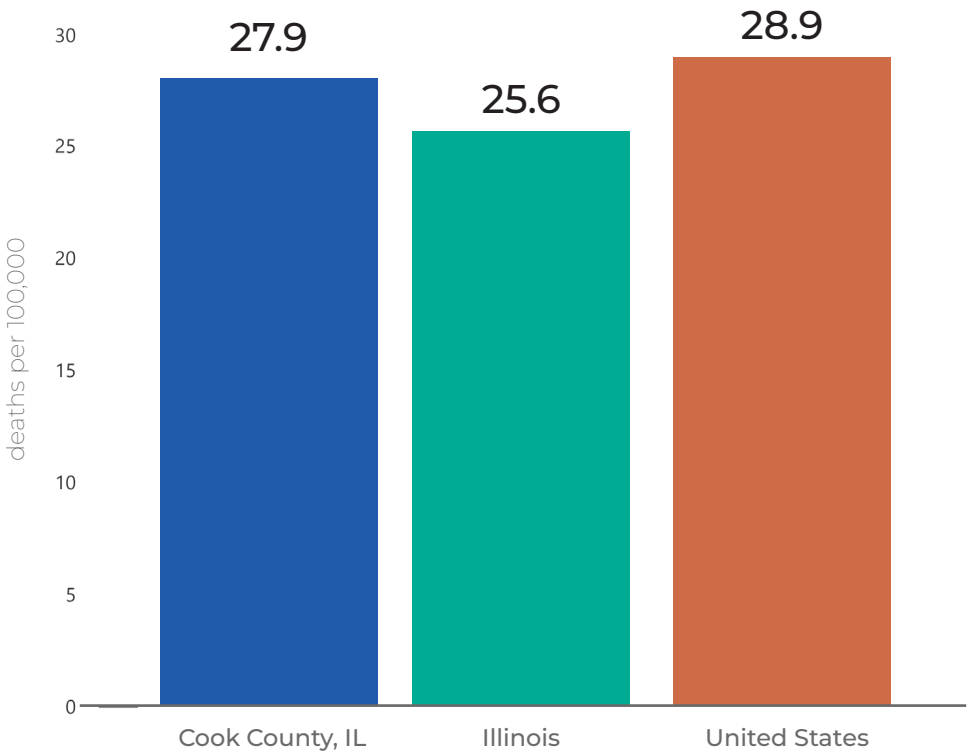


Figure 120.

Chart of Alzheimer's Disease mortality rate per 100,000 population in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024o)



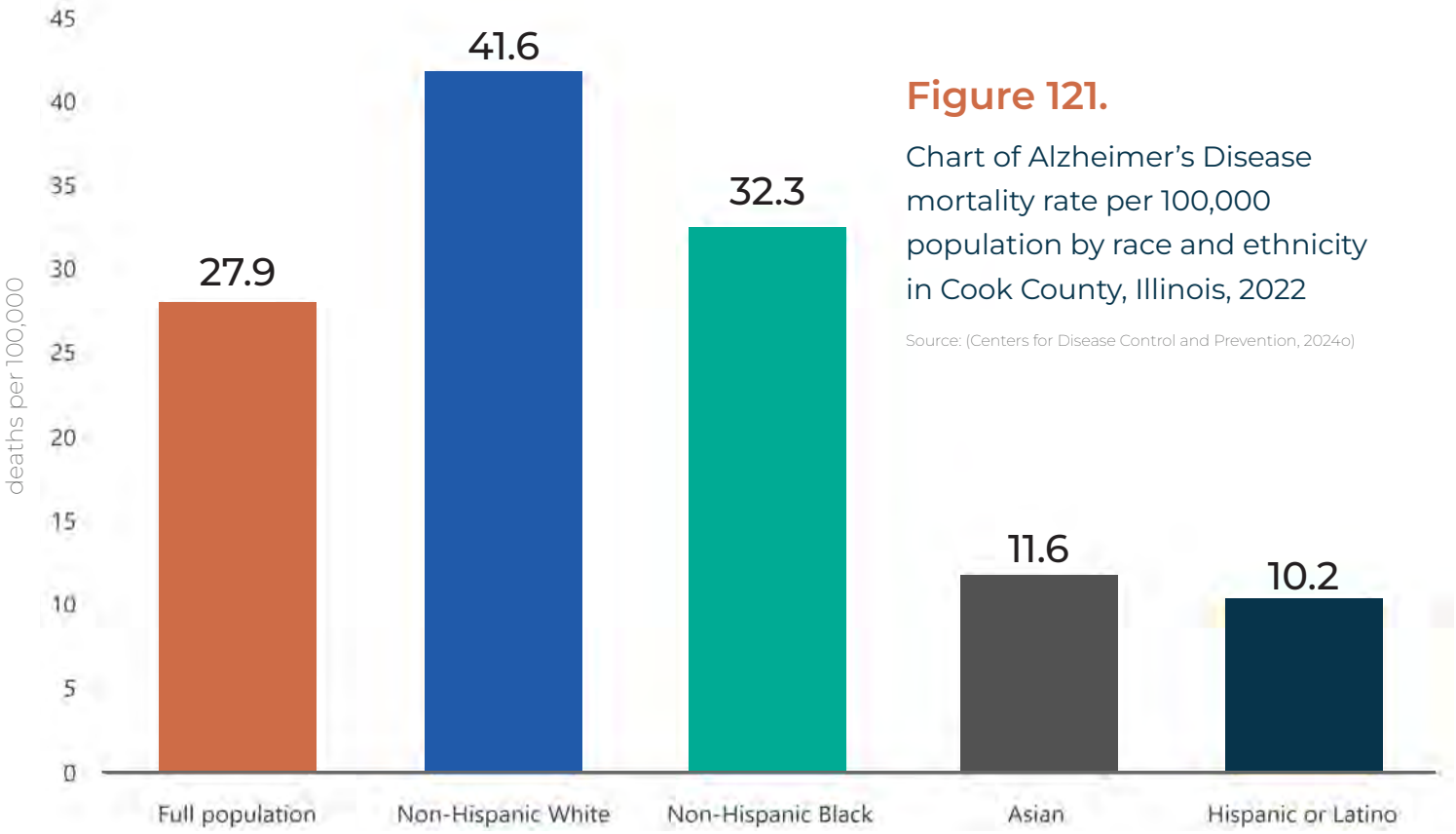


Figure 121.

Chart of Alzheimer's Disease mortality rate per 100,000 population by race and ethnicity in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024o)

SEXUALLY TRANSMITTED INFECTIONS

The burden of sexually transmitted infections (STIs) in Cook County is disproportionately high in communities of color. The higher rates are not caused by ethnicity or heritage but are the result of social conditions that make it harder for people to stay healthy such as poverty, large wealth gaps, lack of access to health insurance and healthcare, and lower education levels (Centers for Disease Control and Prevention, 2024i; J. S. Gonzalez et al., 2009).

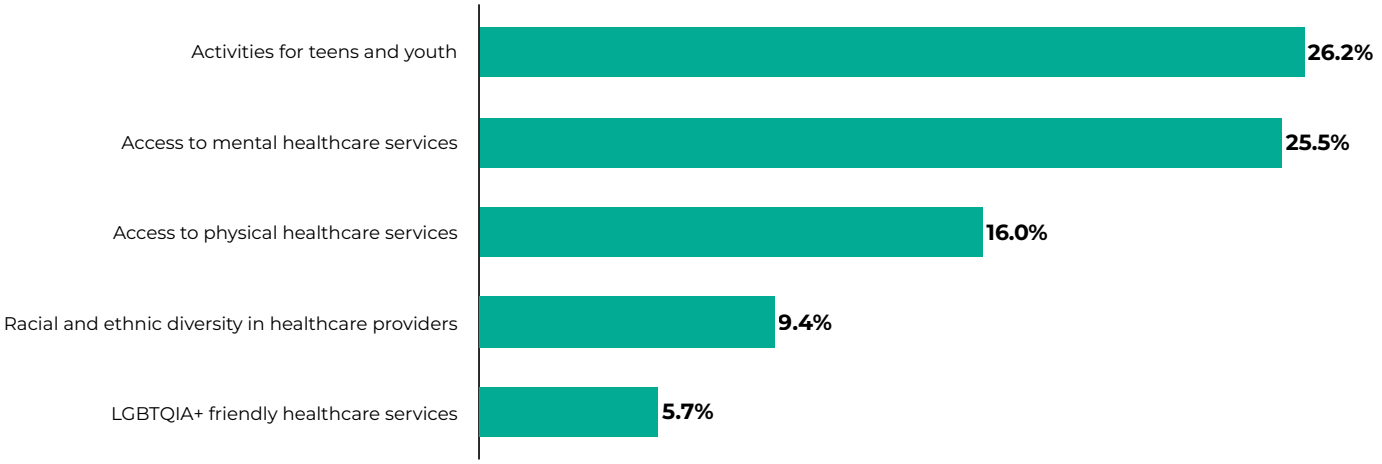
Research shows that barriers to sexual health services also contribute to high disease rates in some communities. People struggling to afford basic needs may have limited access to quality sexual healthcare (Centers for Disease Control and Prevention, 2024i). Additionally, distrust of the healthcare system, especially among marginalized racial and ethnic groups fearing discrimination, can discourage STI testing and treatment (Centers for Disease Control and Prevention, 2024i). In areas with higher STI rates, individuals face a greater risk of infection due to an increased chance of selecting an infected partner (Centers for Disease Control and Prevention, 2024i).

STIs can lead to serious complications, including pelvic pain, pregnancy complications, and pelvic inflammatory disease. They may also cause infertility, chronic pain, organ damage, and increase the risk of certain cancers, such as HPV-associated cervical and rectal cancers (Cleveland Clinic, 2023).

Three percent of community input survey respondents selected sexually transmitted infections as a top health issue (Figure 73). Several STI-related health needs were also selected as top priorities including the ability to access mental and physical healthcare services within a reasonable amount of time, LGBTQIA+ friendly healthcare services, and racial and ethnic diversity in healthcare providers (Figure 122).

Figure 122.

STI-related top health needs selected by survey respondents (n=1782)



Chlamydia

Chlamydia incidence is the number of new cases of chlamydia per 100,000 people. Chlamydia incidence has been decreasing since 2019, however overall chlamydia prevalence is still high in Cook County (Figure 123). Historically the highest burden of chlamydia has been among Non-Hispanic Black residents in Chicago and Suburban Cook County (Illinois Department of Public Health, 2022a) (Figure 124). As previously mentioned, these racial and ethnic difference are largely due to socioeconomic inequities such as poor access to healthcare, segregation, poverty, discrimination, unemployment, and access to quality education.

Figure 123.

Table of chlamydia incidence per 100,000 population in Cook County, Illinois, 2022

	COOK COUNTY CHLAMYDIA INCIDENCE PER 100,000 POPULATION	ILLINOIS CHLAMYDIA INCIDENCE PER 100,000 POPULATION	UNITED STATES CHLAMYDIA INCIDENCE PER 100,000 POPULATION
2019	874.2	631.4	551.0
2022	761.9	557.8	495.0

Source: (Illinois Department of Public Health, 2022a)

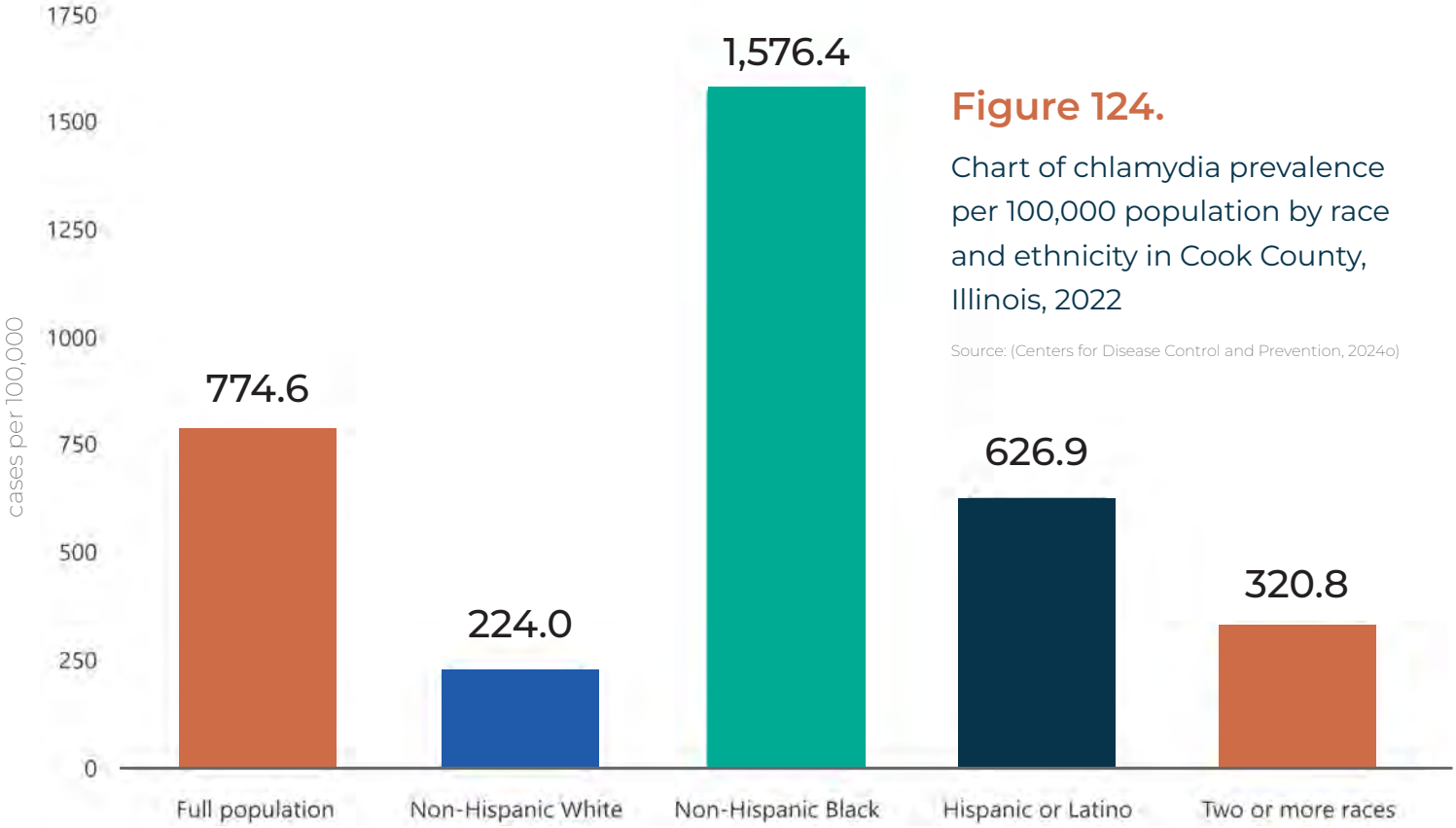


Figure 124.

Chart of chlamydia prevalence per 100,000 population by race and ethnicity in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024o)

Gonorrhea

Gonorrhea is the second most reported STI, primarily affecting people aged 15-24. Treatment is becoming more difficult due to drug-resistant strains (Centers for Disease Control and Prevention, 2024h). Like other STIs gonorrhea rates in Cook County are high and disproportionately impact Non-Hispanic Black residents (Figure 125Figure 126).

Figure 125.

Table of gonorrhea incidence per 100,000 population in Cook County, Illinois, 2022

	COOK COUNTY RATE PER 100,000 POPULATION	ILLINOIS RATE PER 100,000 POPULATION	UNITED STATES RATE PER 100,000 POPULATION
2019	350.0	228.1	187.8
2022	306.5	206.1	194.4

Source: (Illinois Department of Public Health, 2022a)

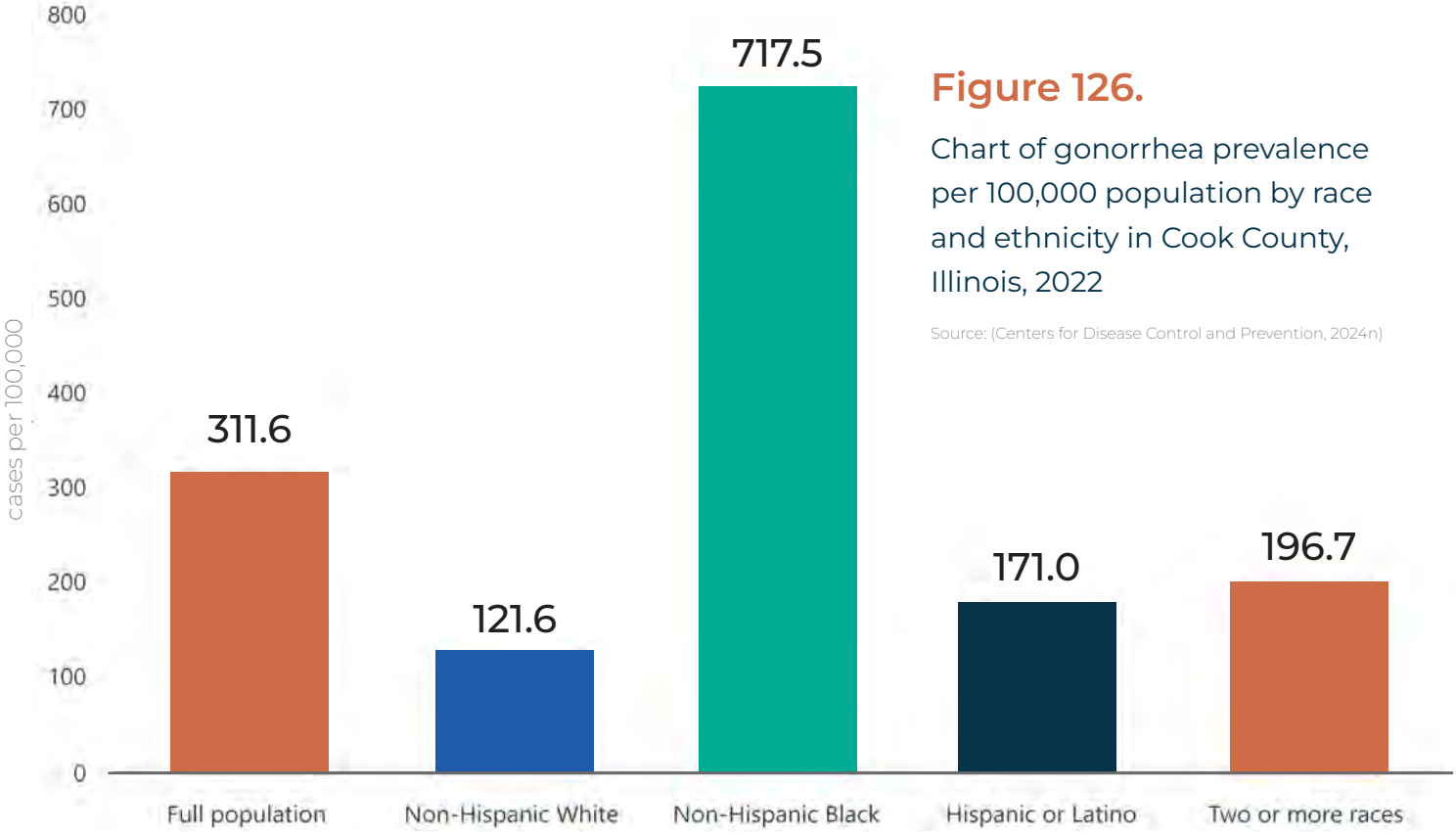


Figure 126.

Chart of gonorrhea prevalence per 100,000 population by race and ethnicity in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024n)

Human Immunodeficiency Virus (HIV)

Human Immunodeficiency Virus, also known as HIV, is a virus that attacks the body's immune system by destroying white blood cells, making it harder for the body to fight off infections and diseases. HIV prevalence measures existing cases per 100,000 people, while HIV incidence tracks new cases. In Cook County, both prevalence and incidence rates are higher than state and national averages (Figure 127). Residents identifying as two or more races have the highest HIV prevalence, nearly three times those of Non-Hispanic Black residents and 13 times those of non-Hispanic white residents (Figure 128). Additionally, an estimated 12% of individuals with HIV in Cook County are unaware of their status (Centers for Disease Control and Prevention, 2022a).

Focus group participants identified HIV as a significant health issue in some communities. Participants also referenced health inequities tied to systemic racism, with Black and Hispanic/Latine individuals facing stereotypes and barriers in accessing equitable care.

Figure 127.

Table of HIV incidence rate (new cases) and prevalence rate (existing cases) per 100,000 population in Cook County, Illinois, 2022

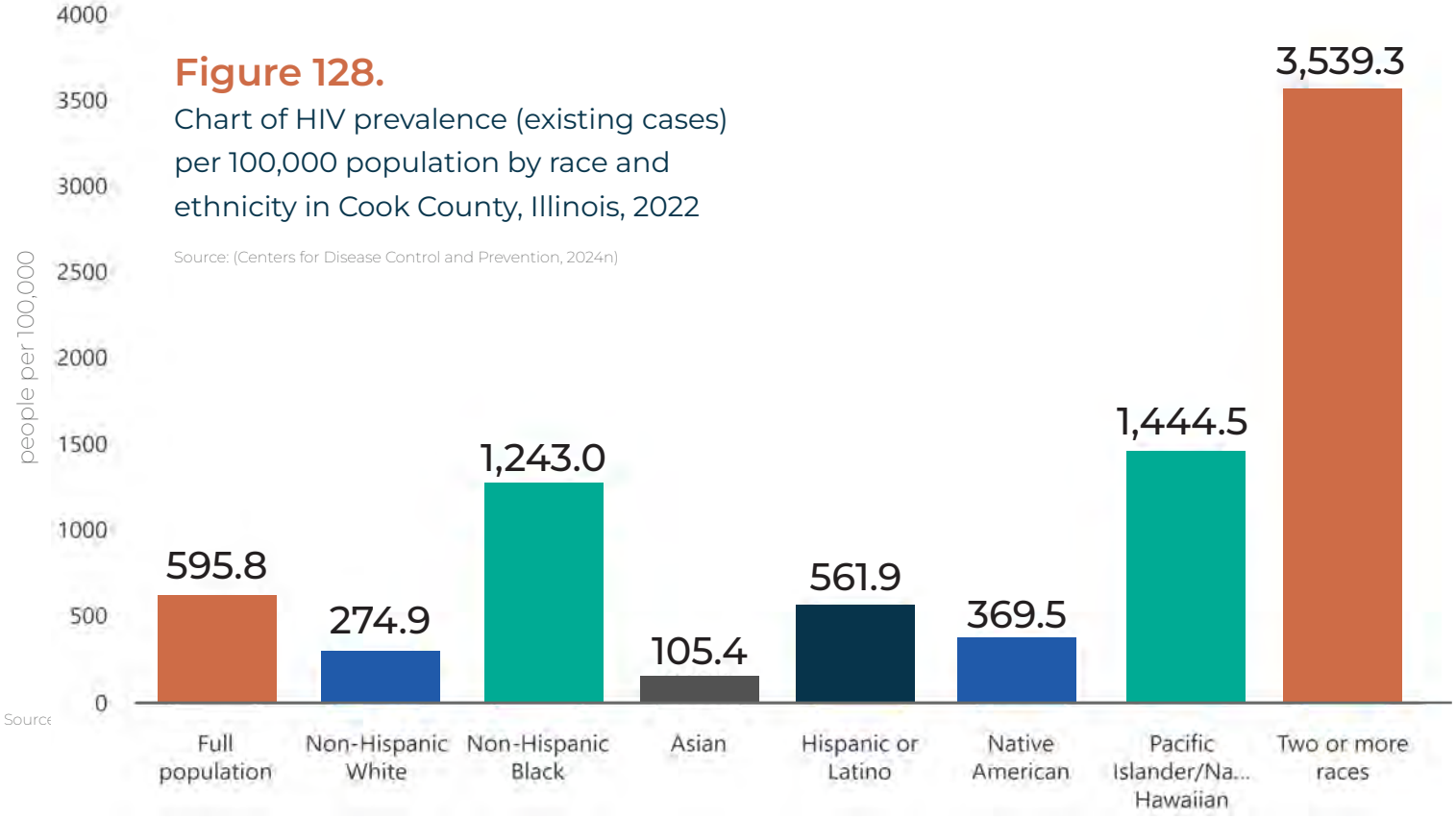
	COOK COUNTY RATE PER 100,000 POPULATION	ILLINOIS RATE PER 100,000 POPULATION	UNITED STATES RATE PER 100,000 POPULATION
HIV incidence (new cases)	15.2	9.6	11.3
HIV prevalence (existing cases)	595.8	338.8	386.6

Source: (Centers for Disease Control and Prevention, 2022a)

Figure 128.

Chart of HIV prevalence (existing cases) per 100,000 population by race and ethnicity in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024n)



COVID-19

COVID-19 is an infectious disease caused by the SARS-CoV-2 virus. Most cases result in mild to moderate respiratory illness, with recovery requiring no special treatment. However, severe illness may occur, particularly in older adults and those with underlying conditions like heart disease, diabetes, chronic respiratory issues, or cancer (K. A. Hacker, 2021; World Health Organization, 2023a). People of any age can become seriously ill or die from COVID-19 (World Health Organization, 2023a). Preliminary research has indicated that socioeconomic factors such as educational attainment, housing, occupation, and prior health status strongly contribute to racial and ethnic COVID-19 inequities (Feldman & Bassett, 2021a).

COVID-19 vaccination significantly reduced the risk of death from COVID-19, with no increased risk of death from other causes (de Gier et al., 2023). In December 2024, the COVID-19 vaccine series completion rate in Cook County (12.3%) was slightly higher than the rate for Illinois overall (10.7%) (Centers for Disease Control and Prevention, 2024s; Chicago Department of Public Health, 2025). Mortality from COVID-19 has been declining but not eliminated. More information on COVID-19 mortality is available in the "Mortality and leading causes of death chapter."

Despite declining mortality rates, the physical effects of COVID-19 infection persist for some. As of fall 2024, 8.7% of people in the United States who had COVID-19 still experienced long COVID-19 symptoms, compared to 4.1% in Illinois, the lowest rate nationwide.

In 2024, Cook County residents continued to feel the lingering health, economic, and social effects of the COVID-19 pandemic. While some focus group participants described life as largely returning to normal, others emphasized ongoing concerns about illness and the need for preventive measures like mask-wearing and social distancing. Many participants expressed confusion about vaccine updates, noting they received initial vaccines and boosters but were unaware of updated booster recommendations.

Participants discussed the physical health effects of COVID-19, including severe illness and long-term complications, as well as widespread mental health challenges such as anxiety, depression, and social awkwardness, particularly among older adults, adolescents, and those living alone. Participants also highlighted the strain on healthcare systems, noting delays in care for both COVID-19 and other conditions, as well as ongoing challenges accessing preventative and primary care.

Economically, families experienced job losses, financial instability, and challenges accessing food, housing, and healthcare, exacerbating existing inequities for low-income and marginalized communities. Participants in several neighborhoods voiced concerns about the discontinuation of programs initiated during the pandemic that helped meet basic needs, stressing the importance of continued assistance.

Survey respondents also expressed continued concern over COVID-19. Five percent of respondents rated COVID-19 as a top health issue in their community. Seventeen percent of survey respondents reported delaying medical care in the past year because of the pandemic. Fifty-one percent of respondents reported not getting a COVID-19 vaccine in the last year, with most citing that they did not want to get vaccinated (Figure 129).

Figure 129.

Community reported attitudes toward COVID-19

SURVEY RESPONSE	PERCENT
Selected COVID-19 as a top health issue	**4.8%**
Reported delaying medical care due to the COVID-19 pandemic in the past year (n=1489)	**17.0%**
Reported not getting a COVID vaccine or booster in the past year (n=1797)	**51.1%**
Reason for not getting a COVID vaccine or booster in the past year (n=926)	**Did not want to get vaccinated ---------- 31.4%** **Prefer not to respond ---------- 11.9%** **I am not at risk ---------- 11.0%** **No insurance ---------- 6.9%** **Wait time for appointment ---------- 6.6%** **Other ---------- 6.4%** **Inconvenient hours ---------- 5.7%** **Cos of service ---------- 5.2%** **Transportation ---------- 3.2%** **Lack of provider ---------- 2.8%**

Reasons for not getting the COVID-19 vaccine that fell into the "other" category included:

- had multiple vaccines/boosters already
- never had covid-19
- had covid-19 already
- lack of reliable information
- distrust of doctors/drug companies/vaccine
- haven't gotten around to it or forgot
- medical restrictions
- too many doses needed
- vaccine doses were ineffective or made covid symptoms worse
- religion
- parents/family not supportive of vaccination
- not offered vaccine by provider.

CLINICAL CARE

There are several complex factors that further influence access to healthcare including proximity; affordability; availability, convenience, accommodation, and reliability; quality and acceptability; openness and approachability; and cultural responsiveness and appropriateness.

And in 2020, hospitals and health systems in Chicago highlighted systemic racism as a key barrier and factor that must be overcome in achieving equitable access to care (UChicago Medicine, 2020).

Based on community conversations and analysis of existing data, The West Chicago assessment under the 2022 Transformation Data and Community Needs Report for Illinois, which includes a focus on socially vulnerable areas in the state, created the following initiative opportunities:

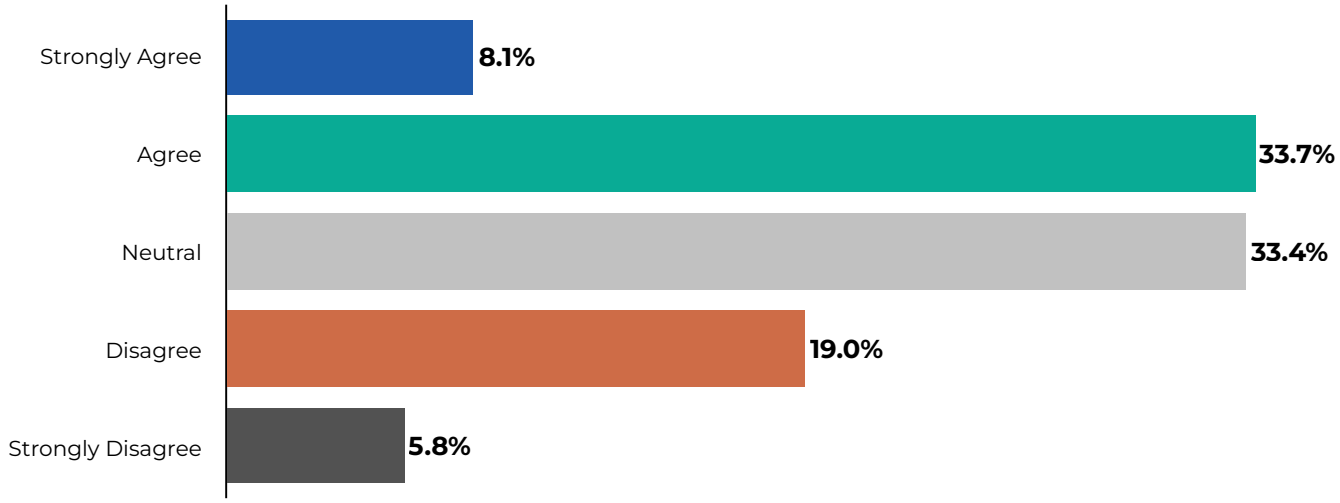
1. Incentivize clinic-community connections to address physical health, behavioral health, and social needs.
2. Promote collaborative care models for chronic illnesses.
3. Build capacity to form relationships between clinics and communities.
4. Promote care engagement by sharing existing health resources to increase awareness.
5. Continuously maintain relationships between hospitals and local communities to reduce and eliminate barriers to care (University of Illinois at Chicago School of Public Health & University of Illinois at Chicago Institute for Healthcare Delivery Design, 2022).

ACCESS TO CARE

Difficulty accessing quality healthcare was frequently cited by both survey respondents and focus group participants as a barrier to health. Easy access to quality mental healthcare and physical healthcare were both selected as top health needs by survey respondents, ranking second and eighth respectively. When asked their agreement with the statement "I am satisfied with the quality of healthcare in my community", a quarter of survey respondents selected "disagree" or "strongly disagree" (Figure 130).

Figure 130.

Survey responses – Agreement with the statement:
I am satisfied by the quality of healthcare in my community (n=1840)



The importance of healthcare access was also emphasized by focus group participants. Residents considered access to nearby clinics, hospitals, and mental health services to be essential.

- **Diverse providers:** Access to trusted healthcare providers contributed to their sense of security and supported their physical well-being. Variety and diversity in healthcare providers and clinical options, including specialty care, was seen as an asset in some communities.
- **Older adult services:** Programs like senior transportation to nearby hospitals, outreach initiatives, and health promotion activities were positively mentioned as supporting access to healthcare.
- **Proximity to health services:** Many respondents discussed their efforts to maintain regular check-ups and utilize available healthcare services. They shared that proximity to clinics, health programs, and wellness centers played a pivotal role in their ability to manage and improve their health.
- **Affordable healthcare:** Free or low-cost clinics were considered valuable resources, especially for uninsured residents.

Focus group discussions highlighted several chronic conditions that are significant concerns for communities in Cook County. Participants linked these conditions to systemic issues such as delayed or inadequate care, financial burdens, and lifestyle and environmental factors. In addition, participants discussed inadequate Medicaid coverage for mental health day programs or residential care.

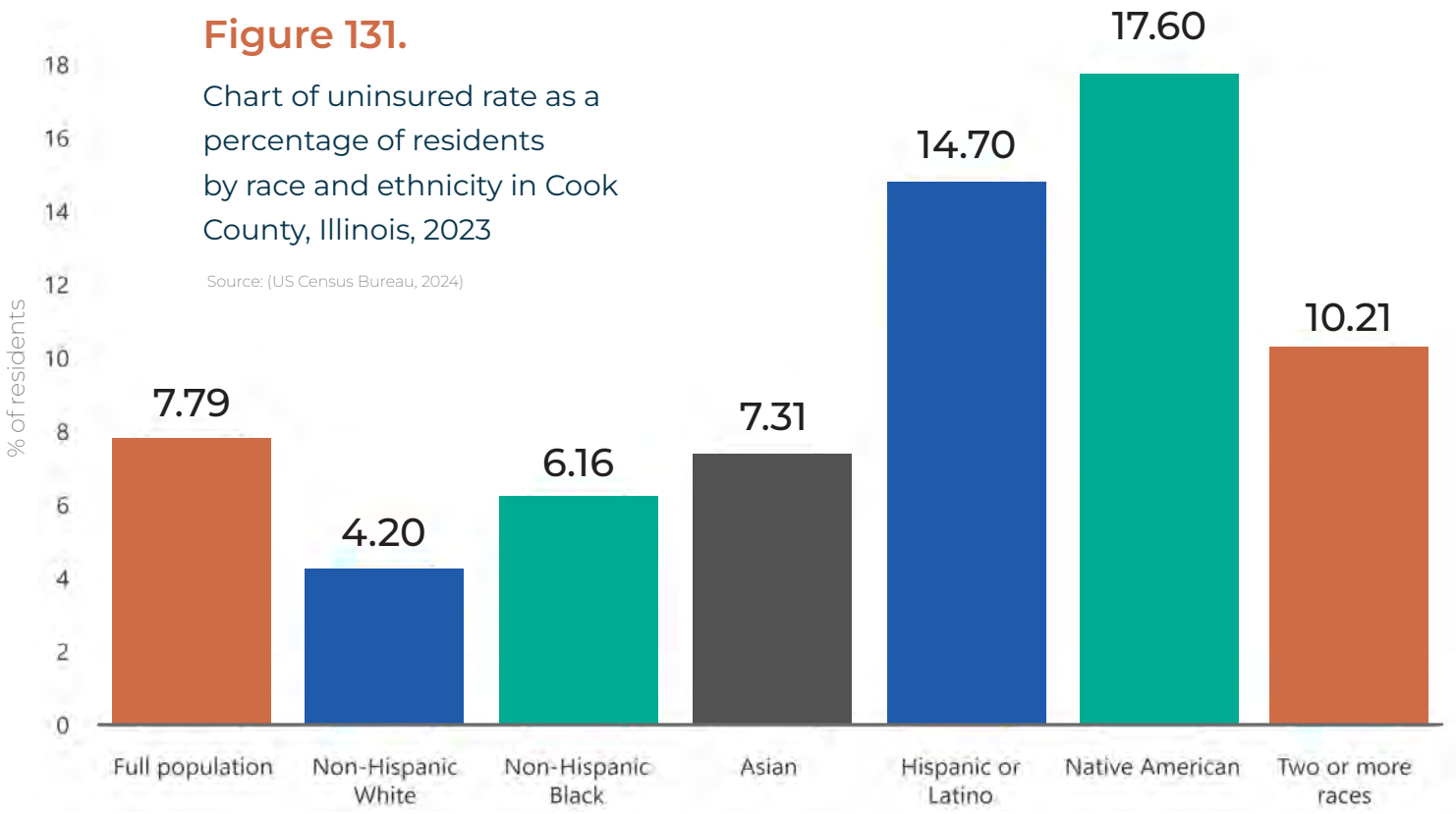
Participants pointed to strain on hospitals and clinics resulting in delayed care for both COVID-19 and non-COVID-related conditions. Participants described how many of the issues have persisted even after the strain of pandemic has eased. This includes continued impacts on access to preventative and primary care.

Within Cook County, 9% of the population does not have health insurance coverage which is greater than the statewide rate of 7.3% (US Census Bureau, 2024). Uninsured rates are higher among certain population groups. For example, in Cook County, uninsured rates among the Hispanic or Latino population (15%) are more than double those of the non-Hispanic white, Non-Hispanic Black, and Asian population (Figure 131). Figure 132 shows the geographic distribution of people without insurance.

Figure 131.

Chart of uninsured rate as a percentage of residents by race and ethnicity in Cook County, Illinois, 2023

Source: (US Census Bureau, 2024)



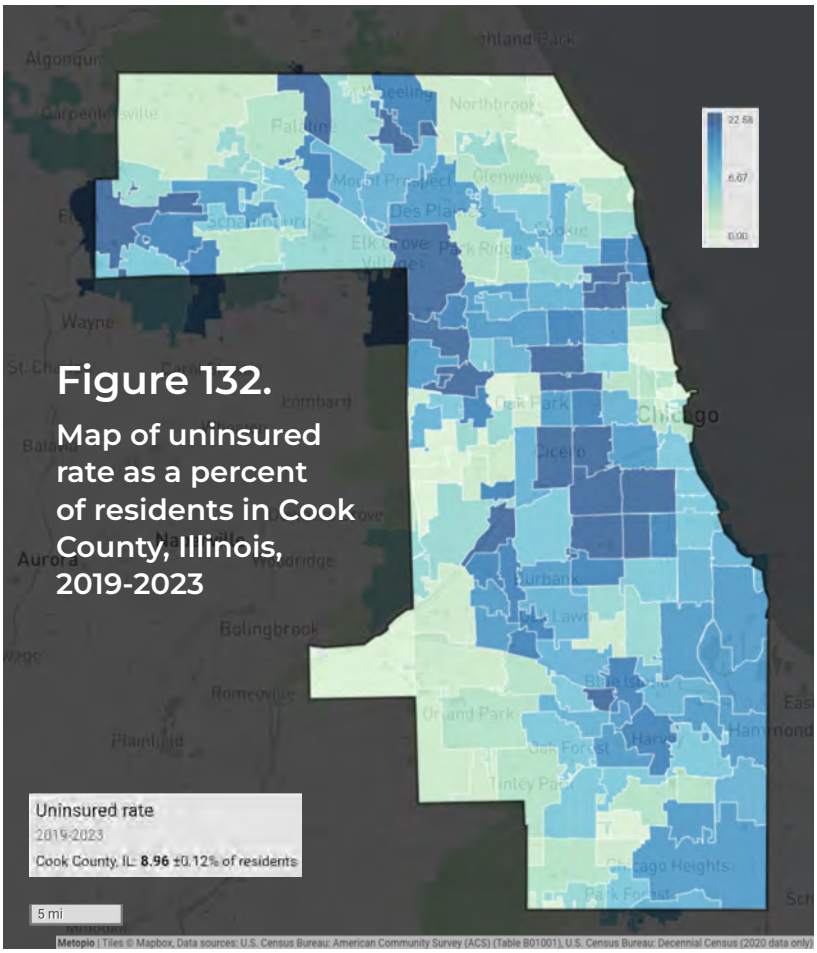


Figure 132.

Map of uninsured rate as a percent of residents in Cook County, Illinois, 2019-2023

Source: (US Census Bureau, 2024)

In focus group discussions, participants have mentioned that it is hard to navigate insurance coverage. They do not know what treatments are paid for and which procedures are out-of-pocket. Additionally, it gets more stressful because employment is tied to their health insurance. If they lose their job, they lose their health insurance which becomes a barrier to care. There was a feeling of frustration in several Cook County residents about how insurance makes healthcare inaccessible.

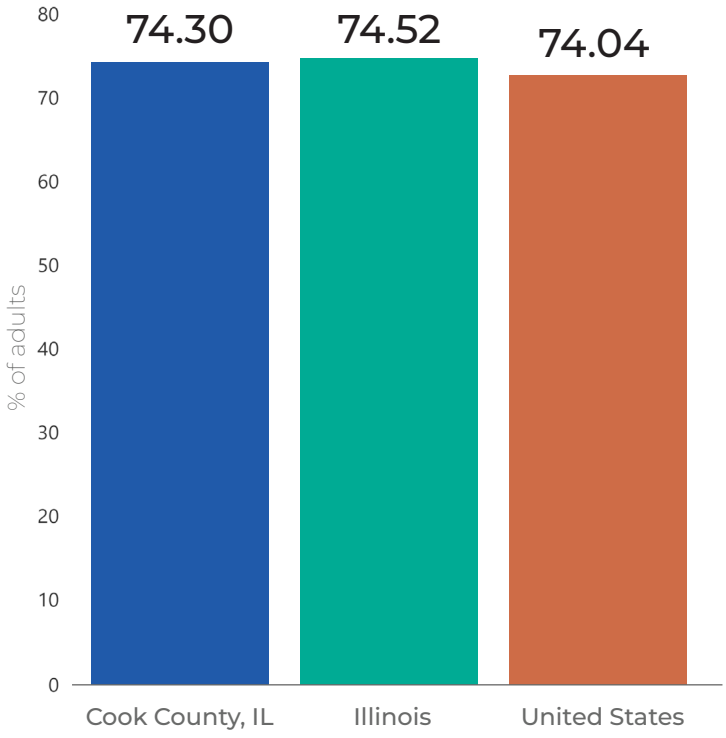
ROUTINE CHECKUPS

Routine checkups are crucial for preventing and detecting diseases early, as well as receiving preventive screenings and vaccines (Centers for Disease Control and Prevention, 2024f). In 2022, 74% of adults in Cook County attended routine checkups (Figure 133). However, Figure 134 shows that suburban Cook County has higher rates of routine doctor visits compared to some Chicago zip codes, where only 67% of residents attend such visits.

Figure 133.

Chart of the percentage of adults that visited a doctor for a routine checkup in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)



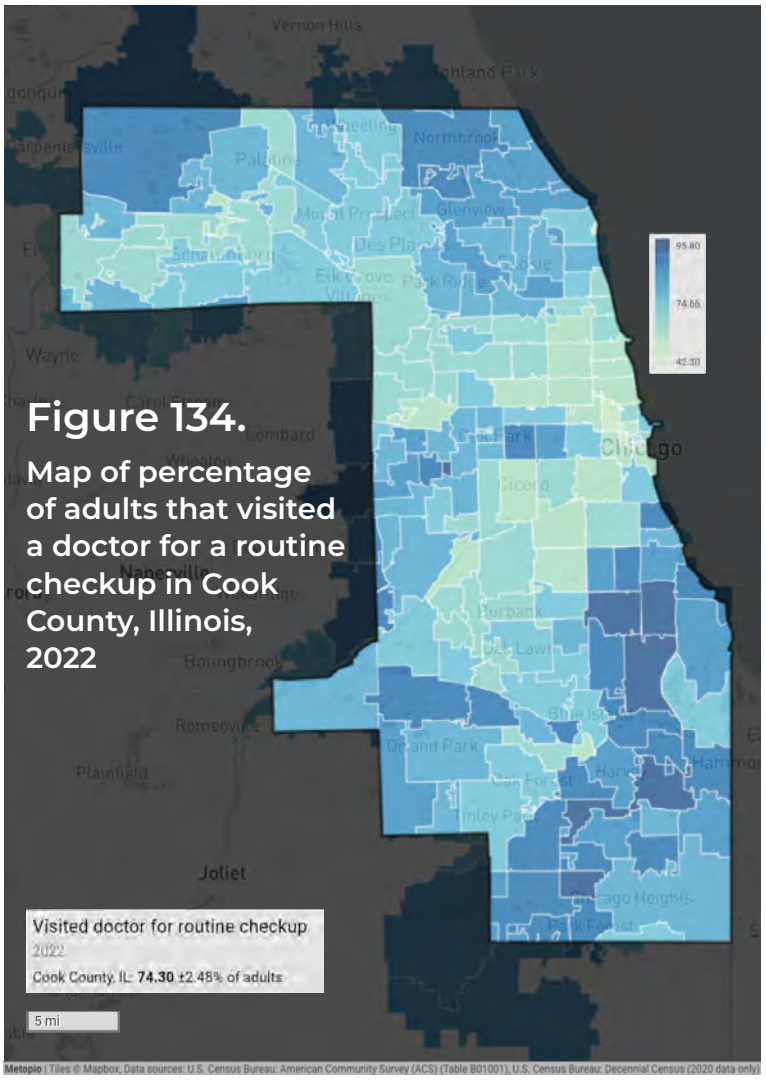


Figure 134.

Map of percentage of adults that visited a doctor for a routine checkup in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

Communities on the South and West Sides of Chicago and in south and west suburbs of Cook County (historically redlined areas) are more likely to have trauma deserts (areas without a nearby level I or II trauma hospital), pharmacy deserts (a community in which residents live more than a half a mile from a pharmacy, and lack access to affordable transportation), and hospitals that are facing capital limitations (Goudie et al., 2021; Tung et al., 2019; University of Illinois at Chicago School of Public Health & University of Illinois at Chicago Institute for Healthcare Delivery Design, 2022). On the North Side of Chicago, which has a majority white population and is more racially and culturally diverse, there are 10 times as many healthcare providers available compared to majority Black/ African American communities on the South and West Sides (Henricks et al., 2017).

Chicago and the surrounding metropolitan area remain one of the most racially segregated areas in the country (Bechteler et al., 2020). Since the 1930s, redlining, home mortgage denial on the basis of race, and government-backed disinvestment in non-white neighborhoods, is at the root of Chicago's history of segregation and inequity. Many historically redlined neighborhoods have become more disinvested over time and are more likely to lack essential resources like healthcare providers and facilities (National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health, 2021).

Research has established that patients living farther away from healthcare facilities have worse health outcomes related to illness survival rates, experience lengthier hospital stays, and have higher rates of non-attendance at follow-up visits (Kelly et al., 2016). Participants who were in the focus groups that took place on the South and West Sides of Chicago mentioned that it takes a lot of effort to find a good primary care provider. While some participants mentioned that they had to travel outside their community to seek healthcare, they also were satisfied with the treatment they received.

DENTAL CARE

Just like having a routine checkup with the doctor, seeing a dentist allows for teeth cleaning and the prevention of oral diseases (Centers for Disease Control and Prevention, 2024t). In the last year only 63% of Cook County adults visited the dentist (Centers for Disease Control and Prevention, 2022b). The dental visitation percentage is low, especially in the south side neighborhoods of Chicago, with percentages as low as 40%. Access to this type of care could impact an individual's health. Figure 135 shows how many adults ages 65 and older have lost all their teeth. As seen in Figure 136, there is a disproportionate percentage of South Side residents who have lost all their teeth. Because of the limited number of providers in South and West Side neighborhoods, residents in those communities do not have the same opportunity to go see a dentist in their area.

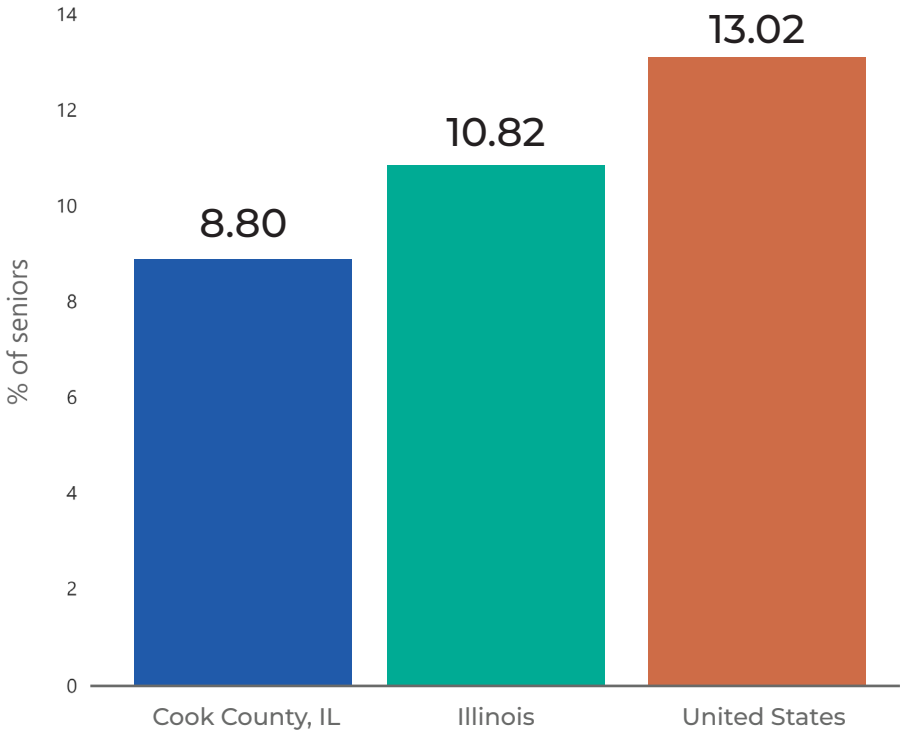


Figure 135.

Chart of people aged 65 years or older that have lost all their teeth as a percentage of older adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

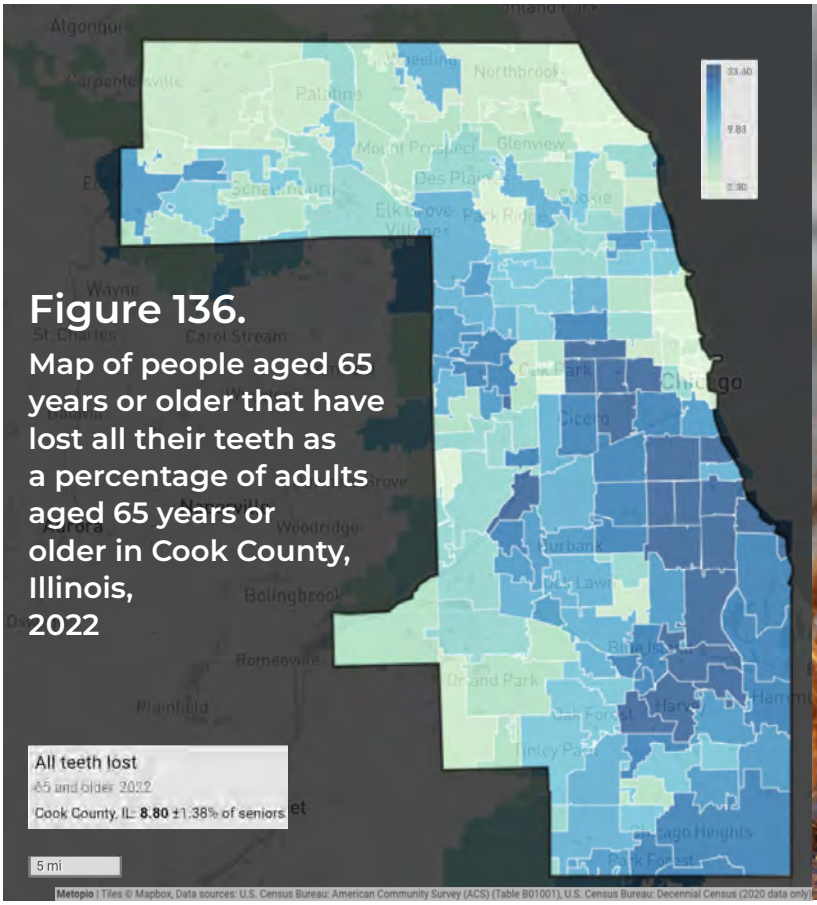


Figure 136.
Map of people aged 65 years or older that have lost all their teeth as a percentage of adults aged 65 years or older in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

PREVENTATIVE CARE

As mentioned before, having a consistent source of primary care provides a chance for patients to be up-to-date with their health, as well as having the ability to do screenings for any health concerns. The following figures give a geographic overview of different types of preventative care:

- **Figure 138:** colorectal cancer screening
- **Figure 140**: cholesterol screening
- **Figure 142:** taking medicine for high blood pressure
- **Figure 145:** older adults who are up to date on clinical preventive services.

A pattern in South and West Side communities like South Lawndale, Cicero, and parts of Humboldt Park shows a smaller percentage of residents receiving preventative care compared to the rest of the city and the suburbs. Because there is limited access to health services on the West and South Sides of the city, those communities do not have as many opportunities to participate in screenings or get the medications they need.

When asked why they did not get a flu or COVID-19 vaccine, many survey respondents reported accessibility issues such as lack of transportation, cost, lack of insurance, inconvenient hours, wait time for appointments, and not having a provider.

Focus group participants described a number of other issues related to the lack of different types of preventative care.

- **Cardiovascular conditions:** Limited access to routine checkups and blood pressure management tools were described as exacerbating cardiovascular conditions.
- **Cancer:** Concerns about access to screening and treatment services for various types of cancer were mentioned. Participants emphasized the need for education on early detection and preventive measures.
- **Mental health:** Participants described a lack of mental health interventions, noting that most care was accessed only during crises. Limited local facilities and the need to travel long distances for services were significant obstacles, especially for residents without reliable transportation. The Cook County Jail was identified as a major mental health facility, reflecting systemic gaps in community-based care.

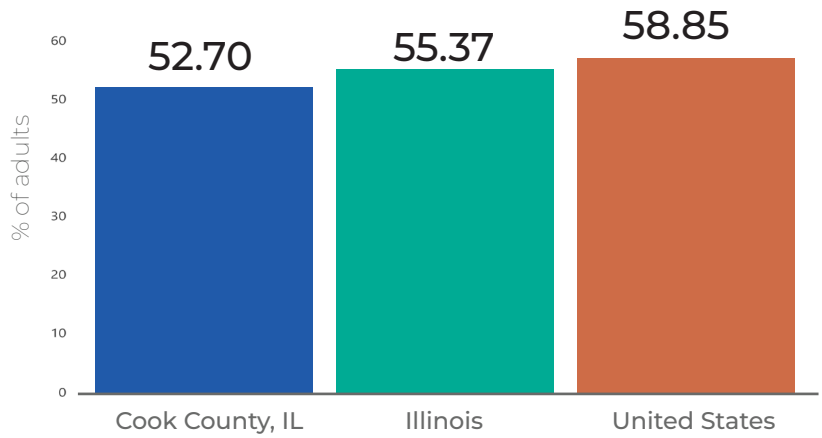


Figure 137.

Chart of colorectal cancer screening rate as a percentage of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

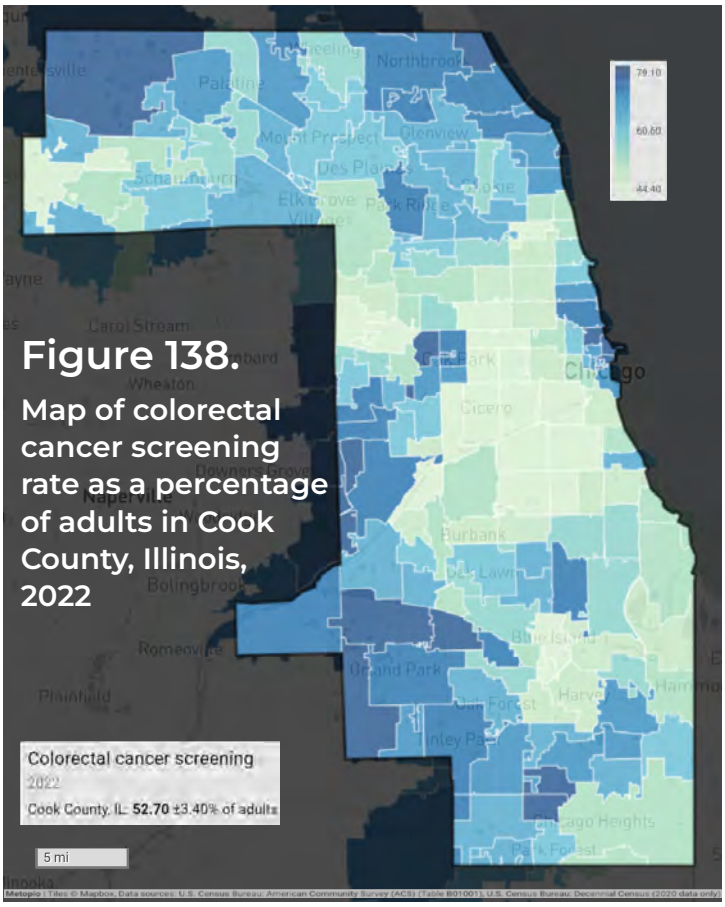


Figure 138.

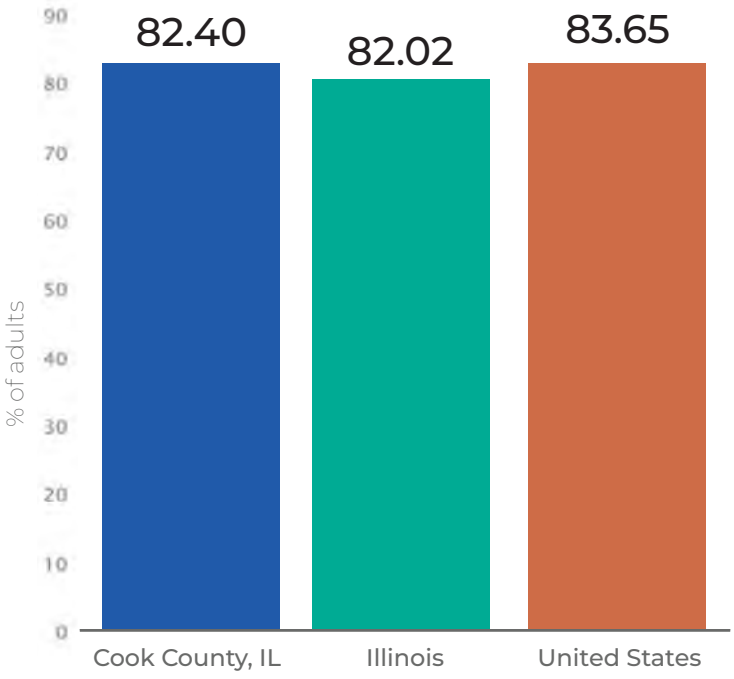
Map of colorectal cancer screening rate as a percentage of adults in Cook County, Illinois, 2022

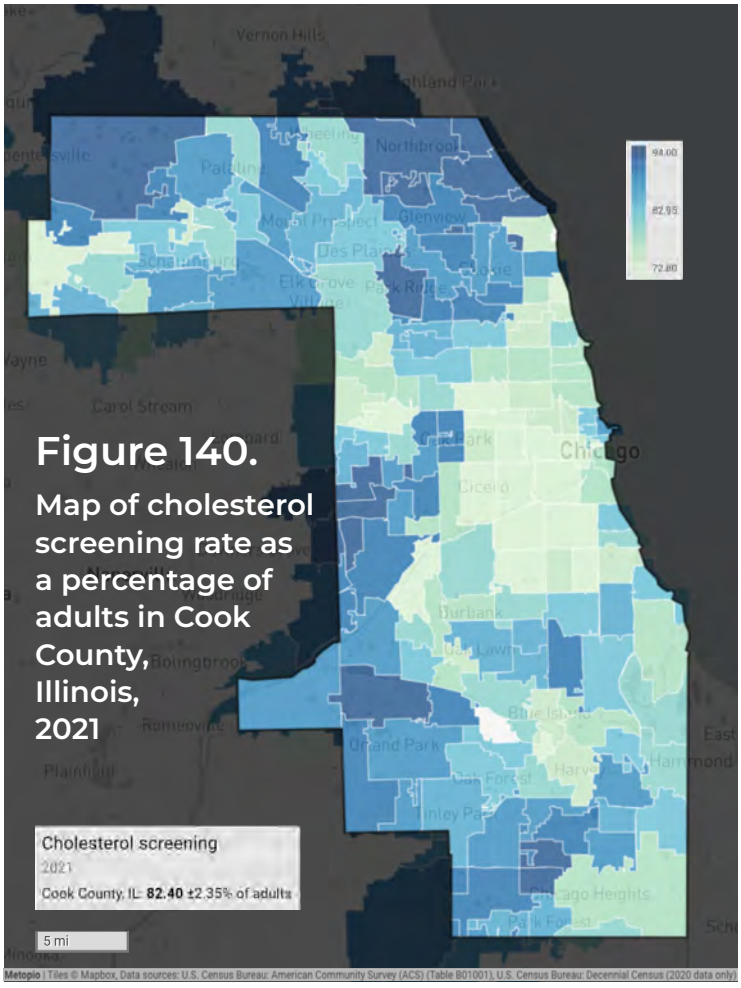
Source: (Centers for Disease Control and Prevention, 2024q)

Figure 139.

Chart of cholesterol screening rate as a percentage of adults in Cook County, Illinois, 2021

Source: (Centers for Disease Control and Prevention, 2024o)



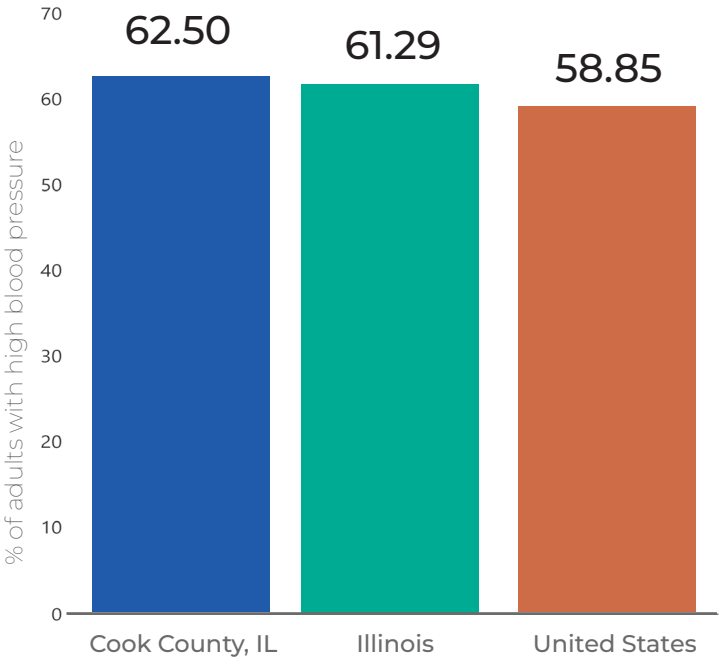


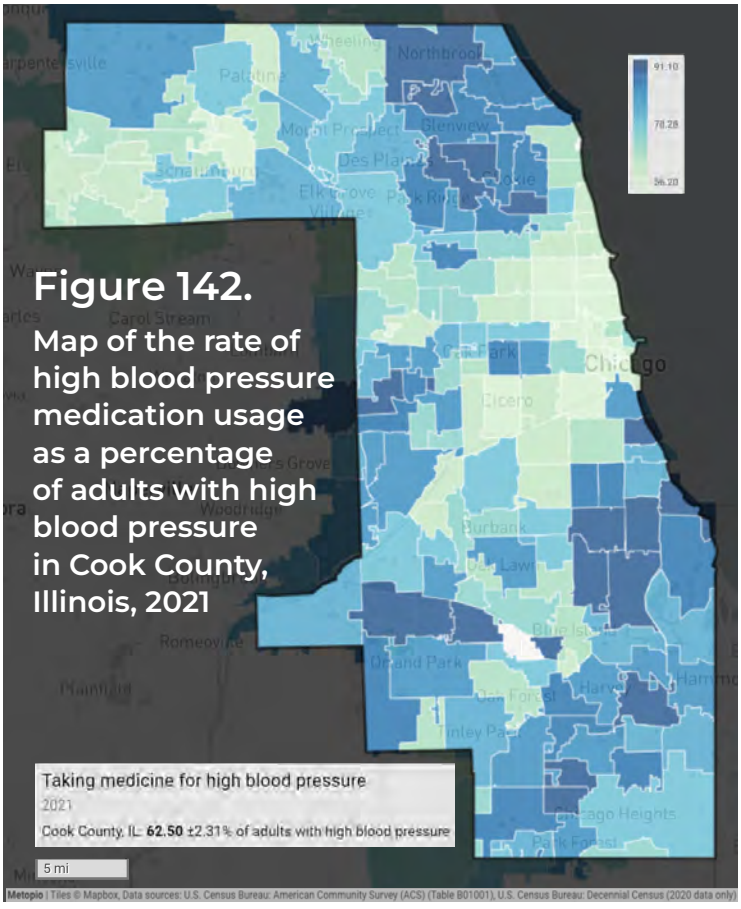
Source: (Centers for Disease Control and Prevention, 2024q)

Figure 141.

Chart of the rate of high blood pressure medication usage as a percentage of adults with high blood pressure in Cook County, Illinois, 2021

Source: (Centers for Disease Control and Prevention, 2024q)





Source: (Centers for Disease Control and Prevention, 2024q)

Figure 143.

Chart of female older adults who are up to date on core preventive services as a percentage of female older adults in Cook County, Illinois, 2020

Source: (Centers for Disease Control and Prevention, 2024q)

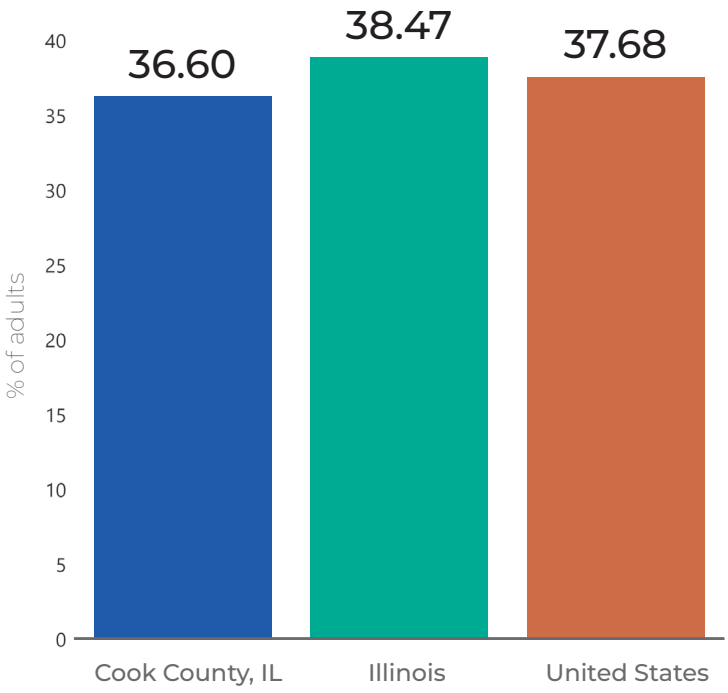
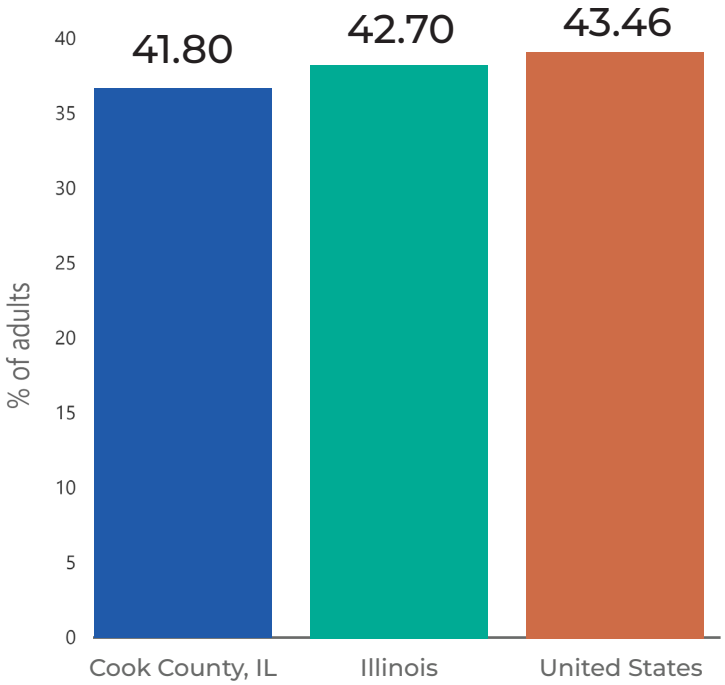


Figure 144.

Chart of male older adults who are up to date on core preventive services as a percentage of male older adults in Cook County, Illinois, 2020

Source: (Centers for Disease Control and Prevention, 2024q)



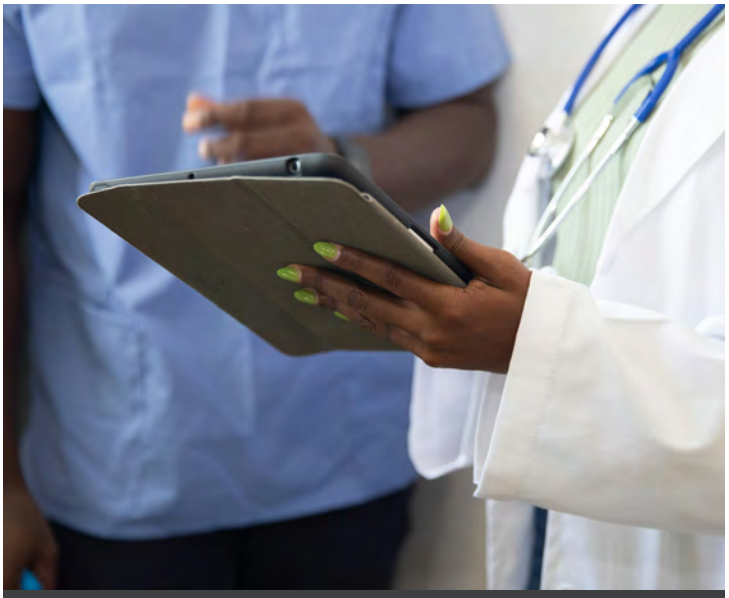
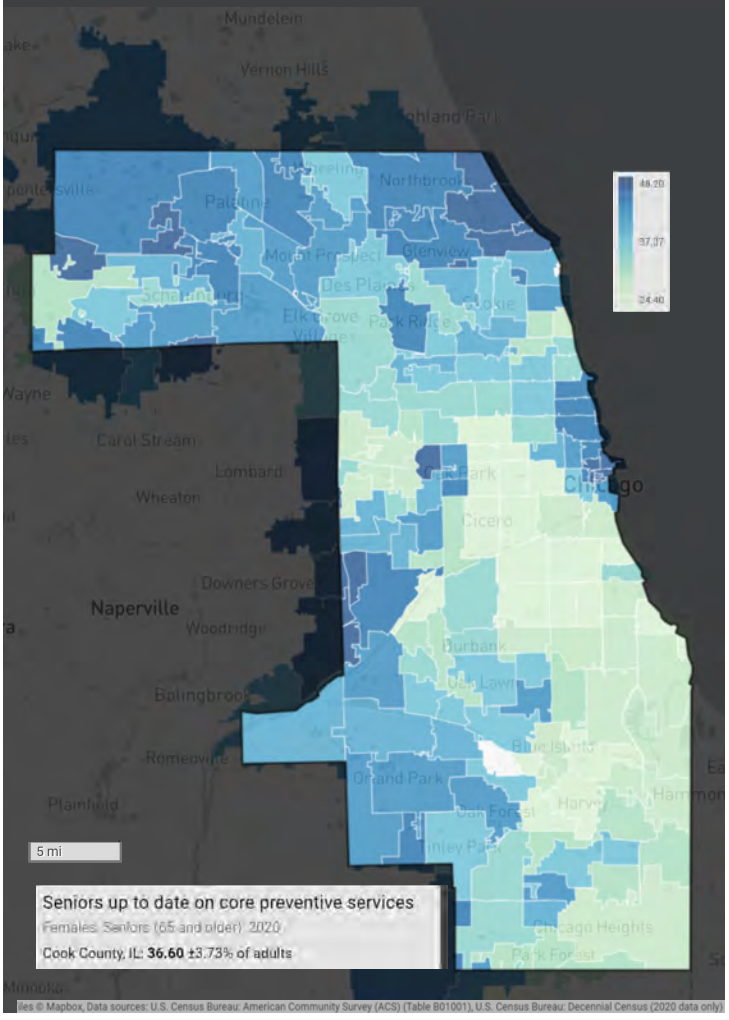


Figure 145.

Map of female older adults who are up to date on core preventive services as a percentage of female older adults in Cook County, Illinois 2020



Source: (Centers for Disease Control and Prevention, 2024q)

AVOIDABLE EMERGENCY DEPARTMENT (ED) VISITS AND PREVENTABLE HOSPITALIZATIONS

Avoidable emergency department (ED) visits are trips to the emergency department that could have been avoided by visiting a non-emergency facility or with better preventative care. ED visits can strain the healthcare system and lead to service overcrowding that results in lower quality care (Udalova et al., 2022). In 2022, 4.8% of ED visits in Cook County and 4.9% of ED visits in Illinois were avoidable (Illinois Department of Public Health, 2022b). In 2023, Chicago had 257.4 avoidable ED visits per 10,000 population, the majority of which were on the South and West Sides (Figure 146). This aligns with the disparities in access to preventative care and other health services.

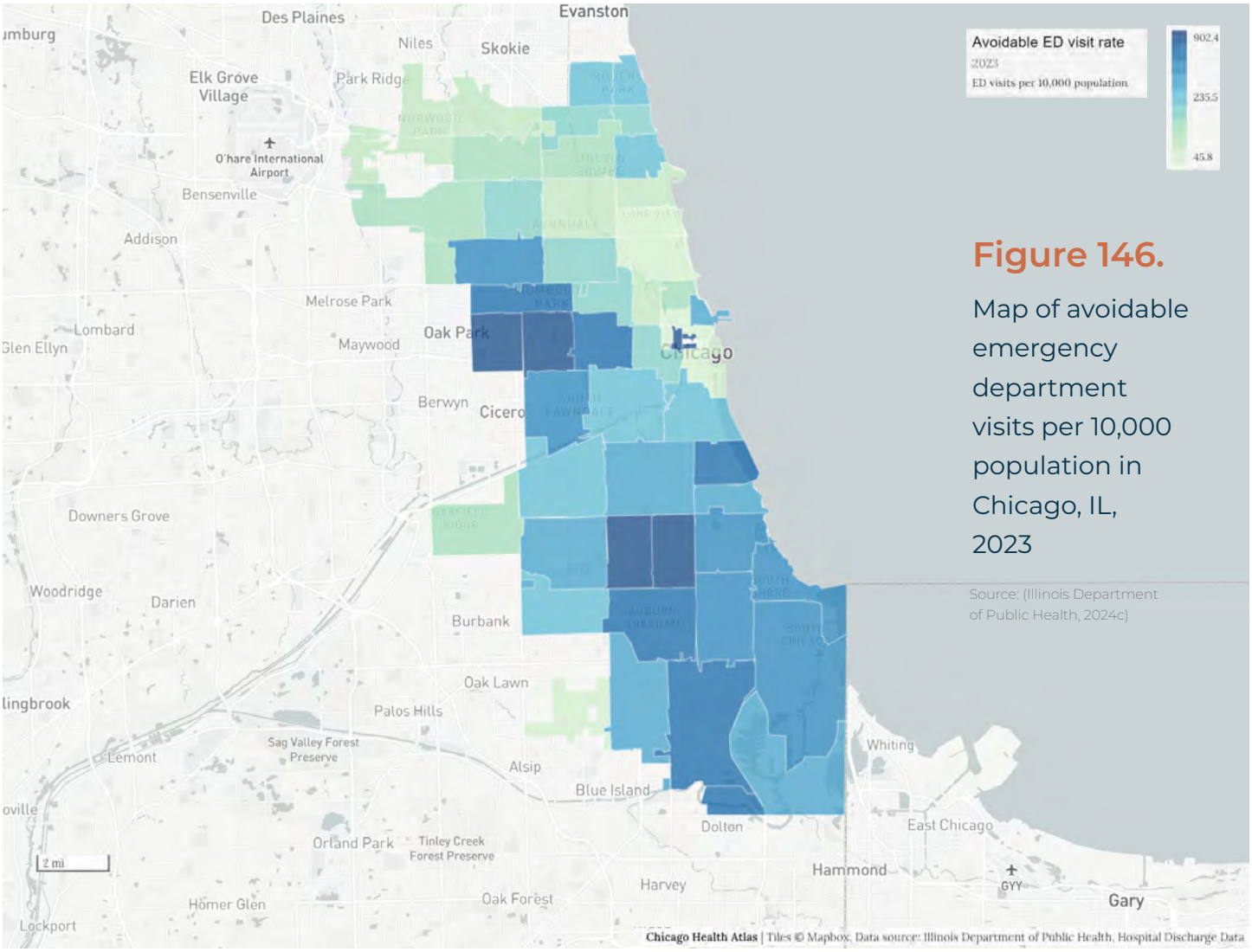


Figure 146.

Map of avoidable emergency department visits per 10,000 population in Chicago, IL, 2023

Source: (Illinois Department of Public Health, 2024c)

Preventable hospitalizations are hospital admissions for acute illnesses or chronic conditions that could have been avoided with better preventative care (O'Brien et al., 2024). These types of hospitalizations are important to examine because they indicate a lack of access to quality primary care. In 2022, Cook County had 3,376 preventable hospital stays per 100,000 Medicare enrollees, which is higher than the rate for Illinois (3,239) and the United States (2,666) (County Health Rankings, National Center for Health Statistics, 2024). In both Chicago and Cook County, preventable hospitalization rates are highest among Black/African American communities (Figure 147) (County Health Rankings, National Center for Health Statistics, 2024).

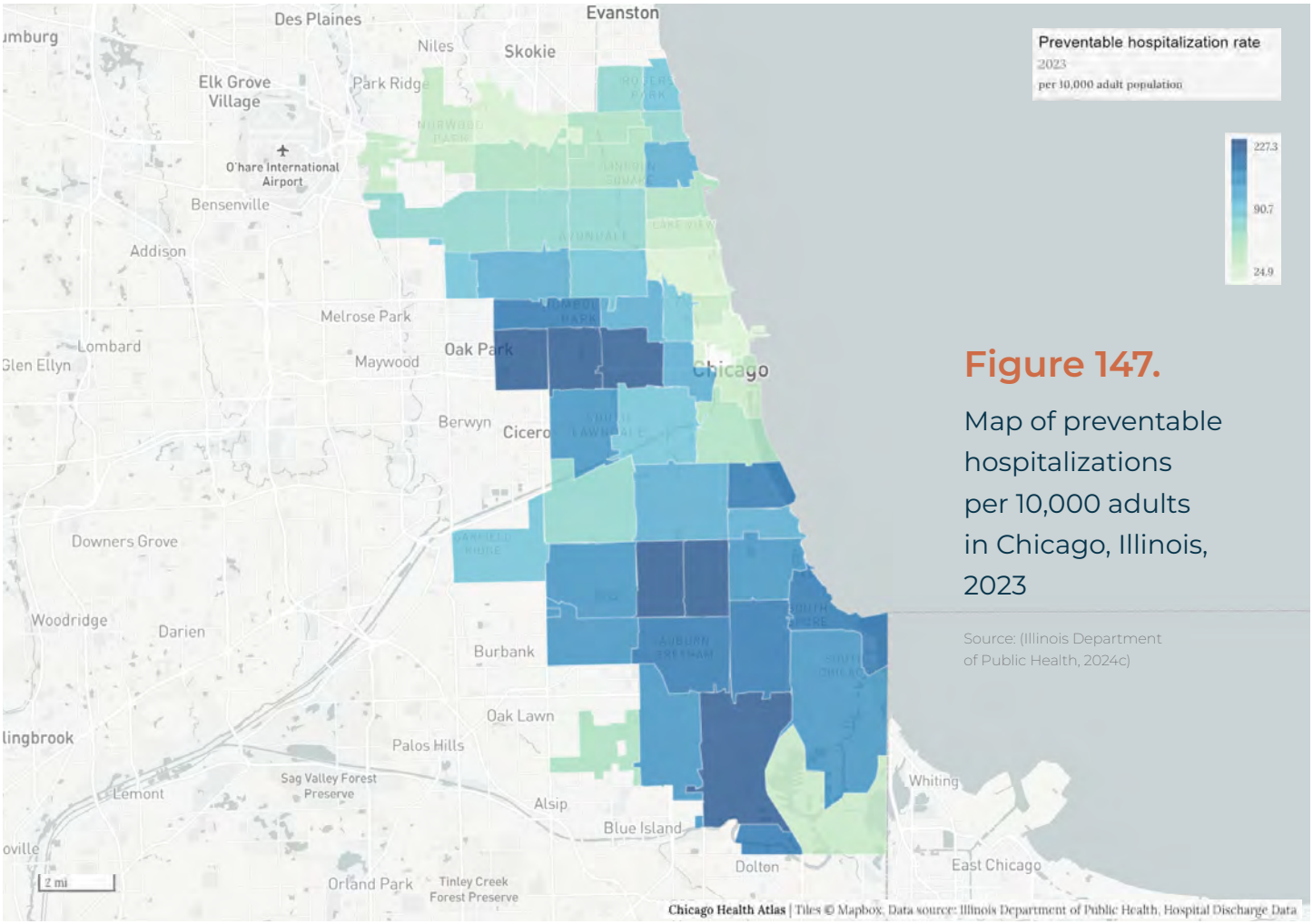


Figure 147.

Map of preventable hospitalizations per 10,000 adults in Chicago, Illinois, 2023

Source: (Illinois Department of Public Health, 2024c)

Community health centers and Federally Qualified Health Centers (FQHCs) have an important role in eliminating disparities in access to healthcare. Community health centers and FQHCs provide primary and preventive care, and many also provide behavioral healthcare as well as oral health, vision, and pharmacy services. By law, FQHCs must serve a federally designated medically underserved area or a medically underserved population; serve all individuals regardless of ability to pay; charge no more than a "nominal fee" to individuals who are classified as low-income, uninsured, and underinsured; and provide non-clinical enabling services to increase access to care, such as transportation, translation, and case management. There are 261 FQHCs in Cook County, 205 of which are in Chicago (Centers for Medicare and Medicaid Services (CMS), 2024b).

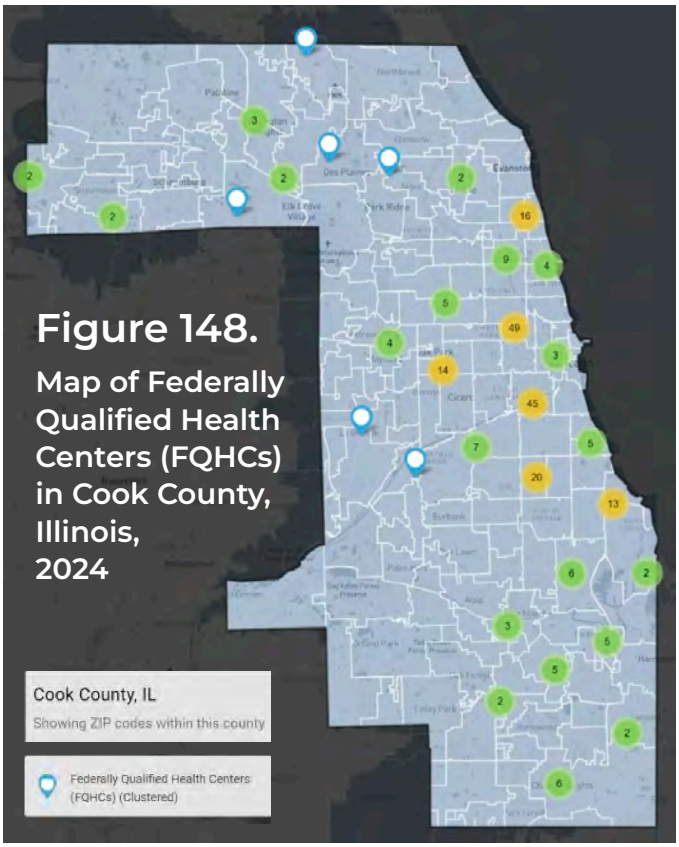


Figure 148.

Map of Federally Qualified Health Centers (FQHCs) in Cook County, Illinois, 2024

Source: (Centers for Medicare and Medicaid Services (CMS), 2024b)

WOMEN'S, MATERNAL, AND INFANT HEALTH

Women's health equity means ensuring all women and those assigned female at birth have a fair and just opportunity to achieve their highest level of health (National Institutes of Health, 2024). Women, including cisgender, transgender, and gender diverse women, face unique health-related challenges and inequities (Figure 149). There was a significant call among focus group participants for greater awareness and resources dedicated to women's health issues such as endometriosis, menopause, and maternal health. In addition, participants emphasized the importance of holistic, compassionate healthcare.

> "But sometimes we don't have a place at home to talk about that. So that leads to them not knowing about their bodies. It's really important. More education for everybody around women's health, our bodies, what to expect as we age, things like that. And, making it culturally relevant because for some cultures it's taboo."
>
> - NAMI Metro Suburban focus group participant

Figure 149.

Examples of key inequities in women's health

- **Reproductive health:** Limited access to reproductive education contributes to disparities in women's health.
- **Chronic conditions:** Women are disproportionately impacted by chronic autoimmune conditions such as lupus, psoriasis, multiple sclerosis, rheumatoid arthritis, and thyroid diseases. And often face issues such as delayed diagnosis.
- **Lack of research and funding:** Conditions such as endometriosis, polycystic ovarian syndrome (PCOS), and menopause remain largely unstudied with limited treatment options available.
- **Neurological conditions:** Girls and women are much less likely to be diagnosed with ADHD and Autism and typically receive diagnoses later in life. The presentations of these conditions have historically been studied in males and can present differently in girls and women leading to diagnostic gaps.
- **Mental health:** Women are more likely to suffer from mental health conditions such as depression and anxiety than men. Research has linked this gap to socioeconomic inequities, gender discrimination, societal expectations, inequities in access to quality healthcare, and other systemic factors.
- **Maternal mortality:** Maternal mortality rates in the U.S. are much higher than any other high-income nation with Black/African American mothers having mortality rates that are 2-4 times higher than any other racial group. More than 80% of maternal deaths are considered preventable.

Sources: (Kulleni Gebreyes et al., 2024, p. 6; National Institutes of Health, 2023, 2024; World Economic Forum, McKinsey Health Institute, 2024; Yu, 2018)

MATERNAL HEALTH

Maternal health refers to the well-being of birthing persons during pregnancy, childbirth, and the postpartum period. This time is crucial for women's health due to increased interaction with and access to healthcare services. It also offers an opportunity to identify, treat, and manage underlying chronic conditions to improve overall health. However, maternal morbidity and mortality remain a public health crisis in Illinois and across the United States. Severe pregnancy complications and maternal deaths are devastating for women, families, and communities (Bennet et al., 2023). Maternal health outcomes continue to vary unequally across racial, socioeconomic, and geographic groups in Illinois (Bennet et al., 2023).

Focus group participants highlighted gaps in prenatal and postnatal care, particularly in underserved areas. Limited resources and fragmented systems prevent many women from receiving adequate maternal health support. Resources for maternal mental health were also described as limited. For women in Hispanic/Latinae communities, cultural stigma around discussing mental health and insufficient availability of Spanish-speaking providers were cited as barriers to maternal mental health support. However, programs that provide support such as regular visits with a doula were described as incredibly beneficial to maternal and child health outcomes.

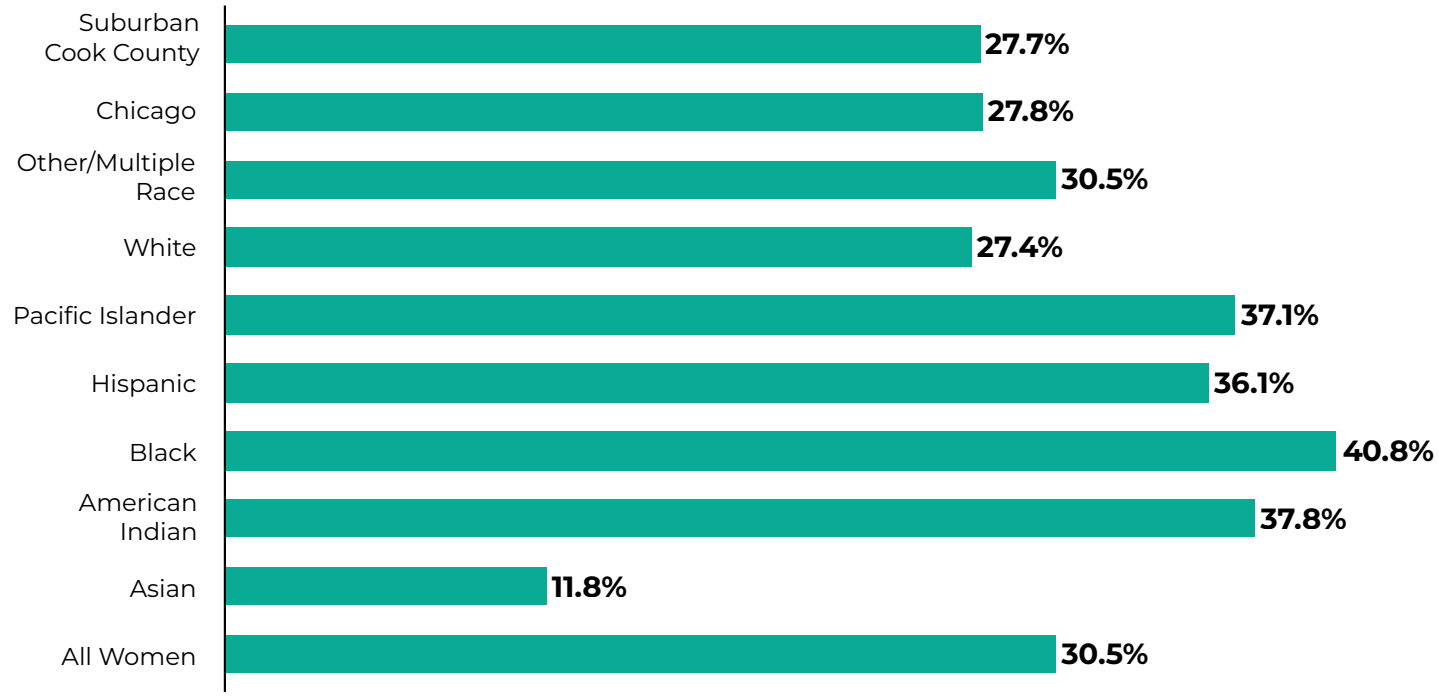
Chronic disease during pregnancy and postpartum

Between 2010 and 2020, maternal health trends in Illinois reveal concerning increases in chronic diseases during pregnancy. Black/African American women had the highest burden of obesity and hypertension during pregnancy and the postpartum period while Asian women had the highest rates of diabetes (Figure 150Figure 152).

Between 2010 and 2020, maternal obesity in Illinois rose by 33%. Maternal obesity increases risks of infant and maternal complications during pregnancy and delivery, including pregnancy loss, birth defects, preterm birth, stillbirth, preeclampsia, and gestational diabetes (Bennet et al., 2023).

Figure 150.

Chart of maternal obesity as a percentage of pregnant and post-partum women in Illinois, 2018-2022

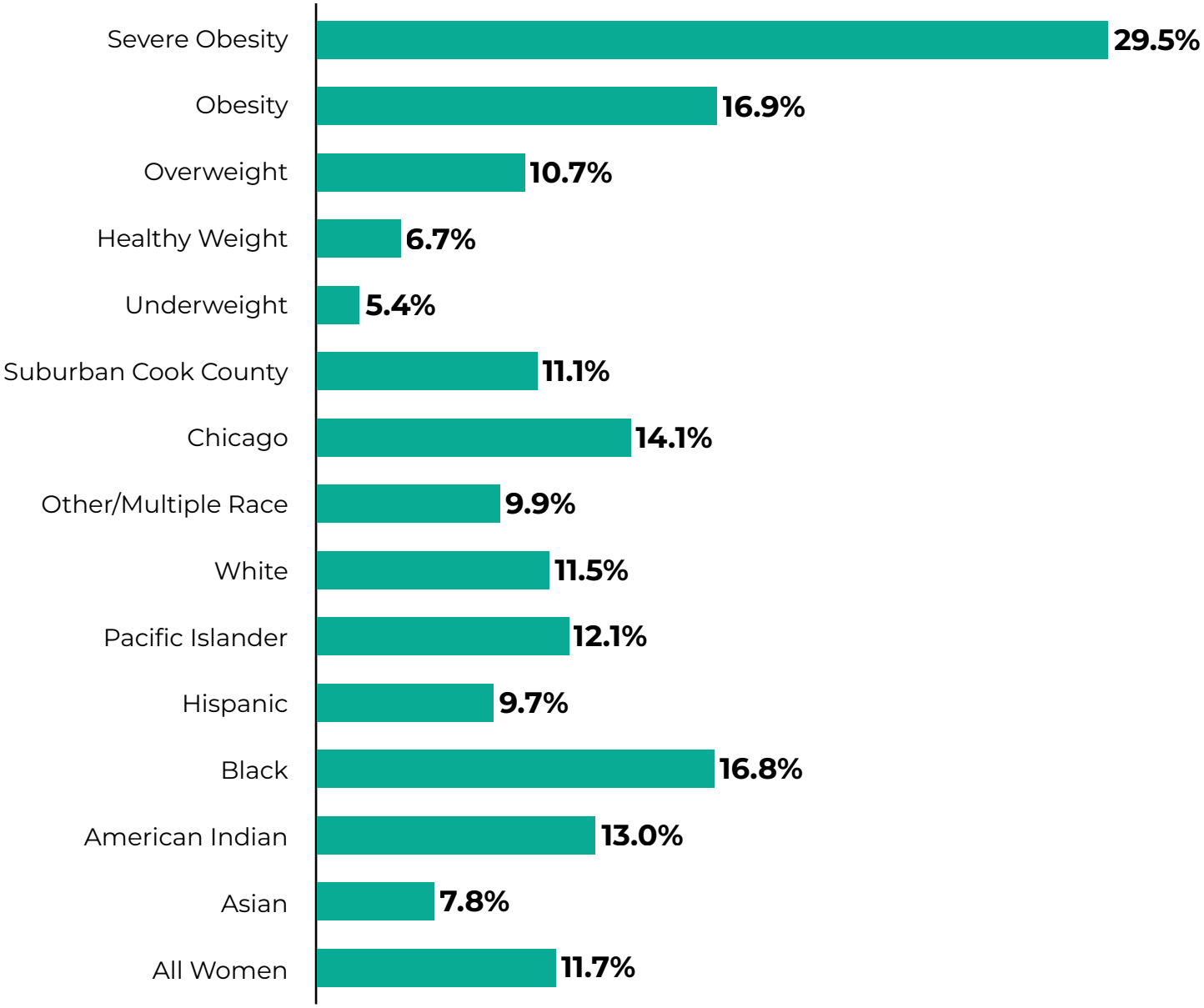


Source: (Bennet et al., 2023)

Pregnancy and postpartum hypertension occur when the pressure of blood pushing against the walls of arteries is consistently too high. When hypertension in pregnancy and/or the postpartum period causes organ damage it is called preeclampsia. Hypertension and preeclampsia can cause pregnancy complications, including premature birth, low birthweight, and problems with the placenta (Bennet et al., 2023). Hypertension and preeclampsia in the postpartum period can cause an increased risk of fluid in the lungs, blood clots, seizures, and stroke (Bennet et al., 2023). In addition, women who have had preeclampsia have an increased risk of kidney disease, heart attack, stroke, and high blood pressure later in life (Bennet et al., 2023). In Illinois, between 2010 and 2020, maternal hypertension rose by an alarming 103% (Bennet et al., 2023).

Figure 151.

Chart of maternal hypertension as a percentage of pregnant or post-partum women in Illinois, 2018-2022

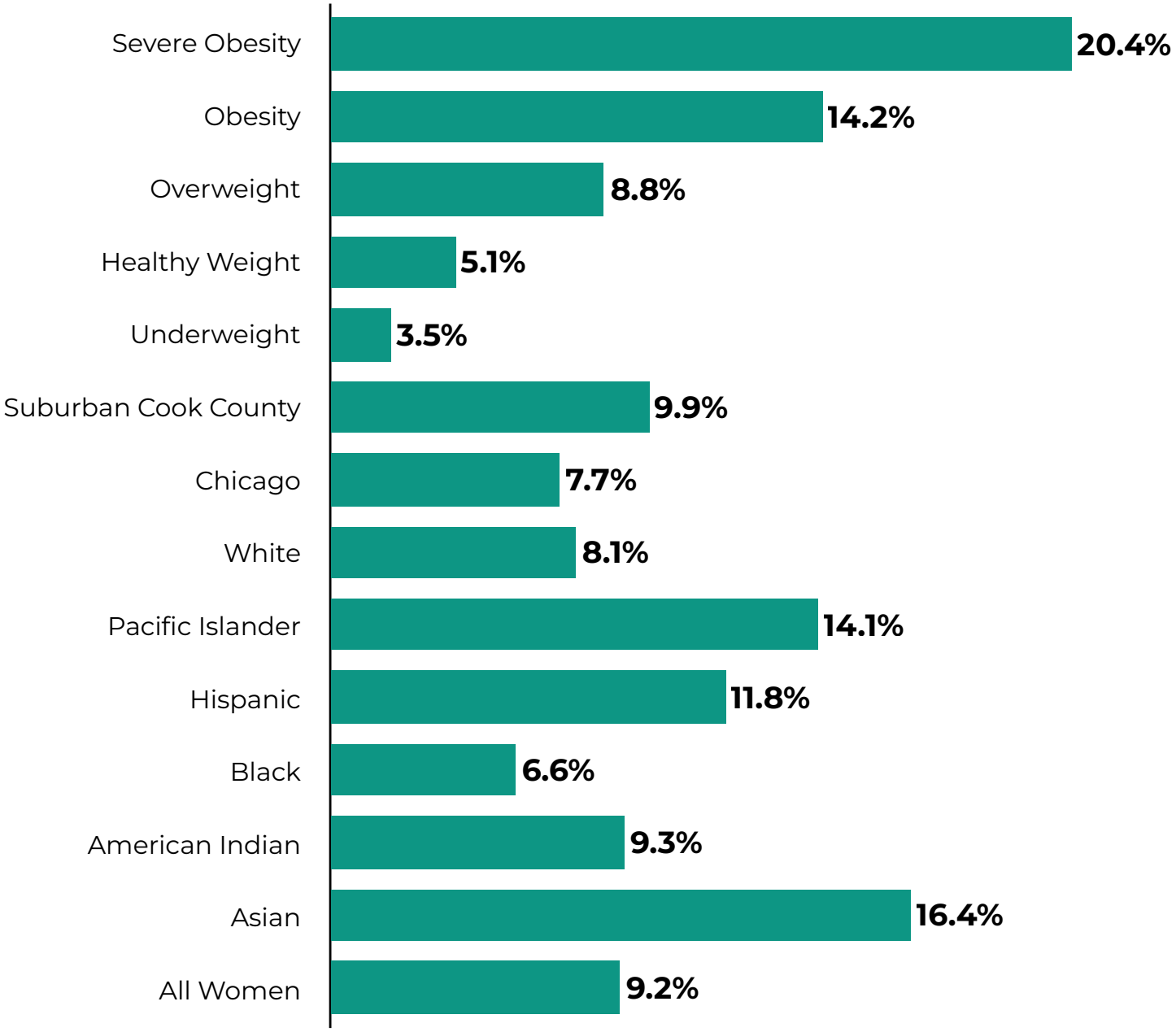


Source: (Bennet et al., 2023)

Chronic diabetes occurs when a person's body doesn't produce enough insulin or can't use insulin properly. Some women develop gestational diabetes during pregnancy, which may resolve afterward. However, any type of diabetes during pregnancy increases the risk of birth defects, stillbirth, preterm birth, or cesarean delivery (Bennet et al., 2023). Gestational diabetes also raises the mother's risk of high blood pressure, preeclampsia, and future diabetes. In Illinois, between 2010 and 2020, the percentage of women with diabetes giving birth rose by 68% (Bennet et al., 2023).

Figure 152.

Chart of maternal diabetes as a percent of pregnant or post-partum women in Illinois, 2018-2022



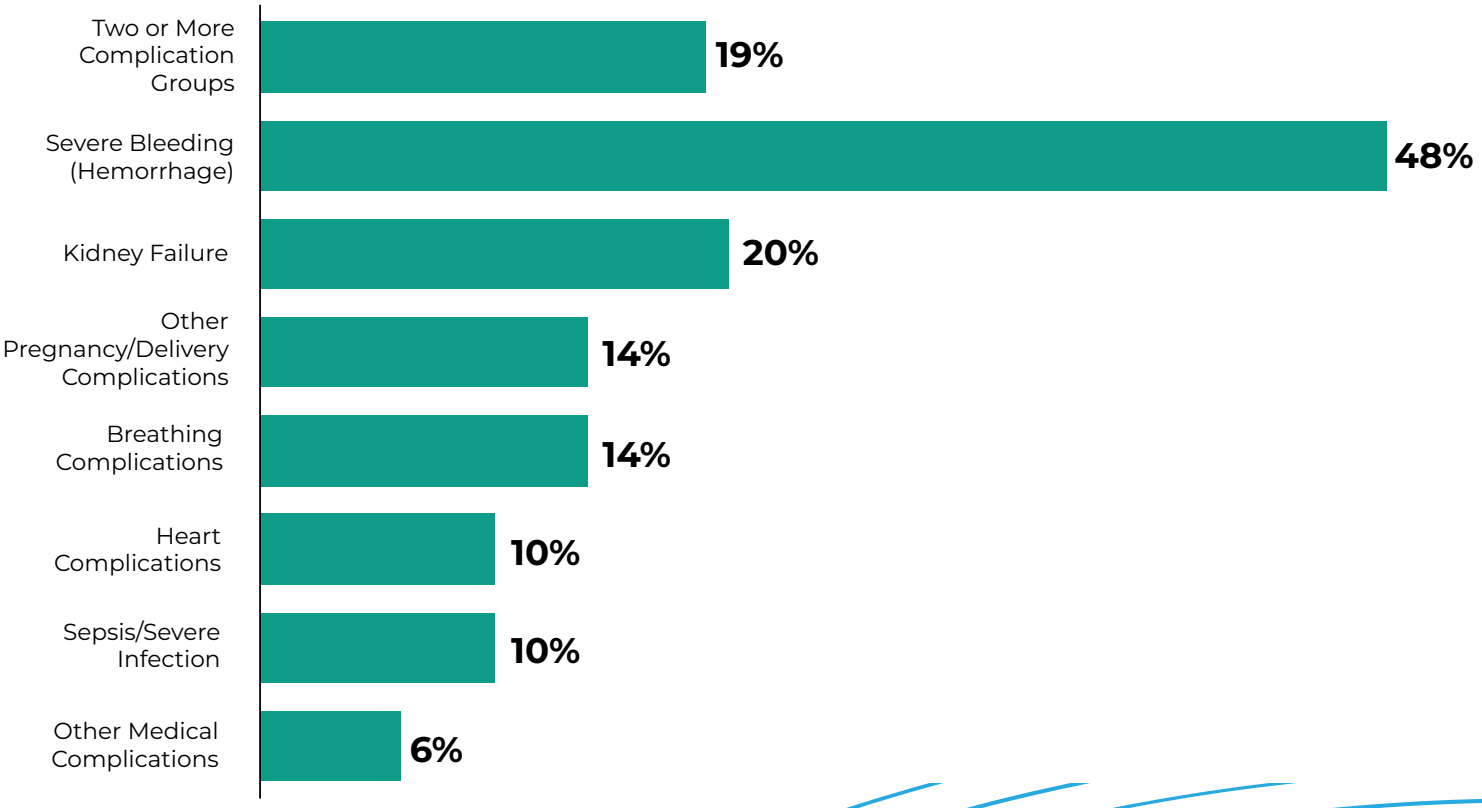
(Bennet et al., 2023)

Severe maternal morbidity and mortality

Severe maternal morbidity (SMM) includes unexpected, life-threatening complications during labor and delivery, some of which can cause long-term health issues beyond pregnancy (Bennet et al., 2023). Figure 153 shows the types of severe complications experienced by women in Illinois from 2018-2020. SMM is most common among Illinois women who are Black/African American, are age 40 or older, have Medicaid insurance, and live in Chicago (Bennet et al., 2023).

Figure 153.

Chart of the causes of severe maternal morbidity, 2018-2020



Source: (Bennet et al., 2023)

Maternal mortality is the death of a woman during or after pregnancy. Pregnancy-related mortality ranged between 83 and 110 deaths for the years 2018-2020 (Figure 154). As with SMM, Black/African American women had the highest rates of maternal mortality (Bennet et al., 2023).

Figure 154.

Table of pregnancy-related death count over time in Illinois, 2018-2020

PREGNANCY-ASSOCIATED DEATHS	
YEAR	**NUMBER**
2018	83
2019	70
2020	110

Source: (Bennet et al., 2023)

INFANT MORTALITY

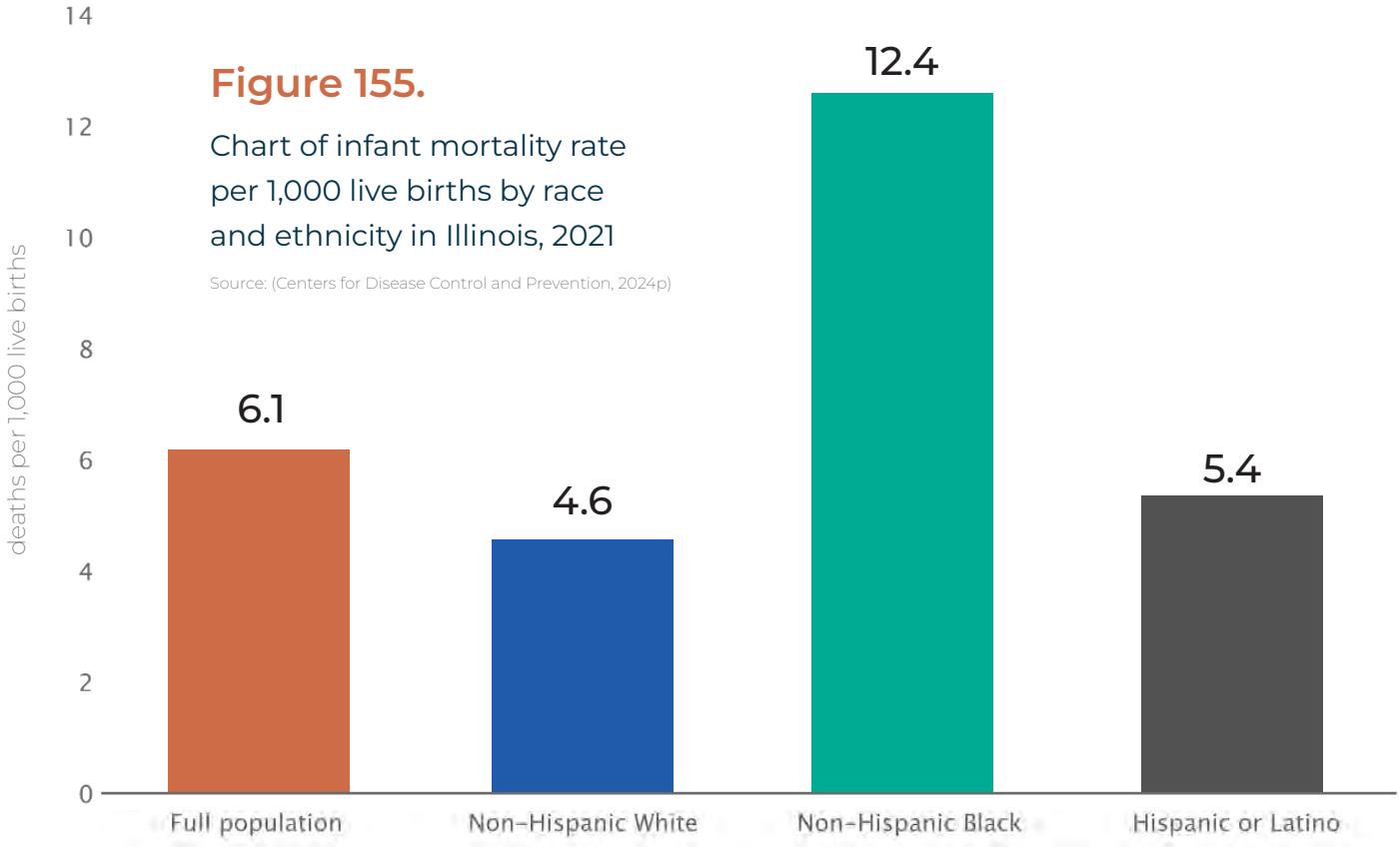
Infant mortality is defined as the death of an infant before their first birthday. Like maternal mortality, infant mortality is an important indicator of overall community health because it can be directly connected to social influencers of health such as living conditions, economic stability, and access to quality medical care (Centers for Disease Control and Prevention, 2024k; Illinois Department of Public Health, 2024e). Focus group participants highlighted health inequities among infants and children, noting higher mortality rates for Black and Brown children. Parents and caregivers reported challenges accessing routine pediatric and specialty care, particularly in underserved areas, leading to gaps in regular checkups, immunizations, and health screenings.

In 2021, Illinois had an infant mortality rate of 5.6 deaths per 1,000 live births, slightly higher than the national rate of 5.4 (Illinois Department of Public Health, 2024e). Inequities in infant health persist (Figure 155). Non-Hispanic Black infants consistently had a mortality rate two to four times higher than non-Hispanic white, Hispanic or Latino, and Asian or Pacific Islander infants between 2012 and 2021 (Illinois Department of Public Health, 2024e). During this period, infant mortality rates for non-Hispanic white, Non-Hispanic Black, and Hispanic or Latino infants showed little change, while the mortality rate for Asian or Pacific Islander infants declined by an average of 6.4% annually, reaching the lowest rate of 2.4 deaths per 1,000 live births in 2021 (Illinois Department of Public Health, 2024e). Research has established that racial disparities in infant mortality are linked to systemic racism, chronic stress, healthcare access, education, economic stability, and neighborhood conditions (Centers for Disease Control and Prevention, 2024k; Illinois Department of Public Health, 2024e).

Figure 155.

Chart of infant mortality rate per 1,000 live births by race and ethnicity in Illinois, 2021

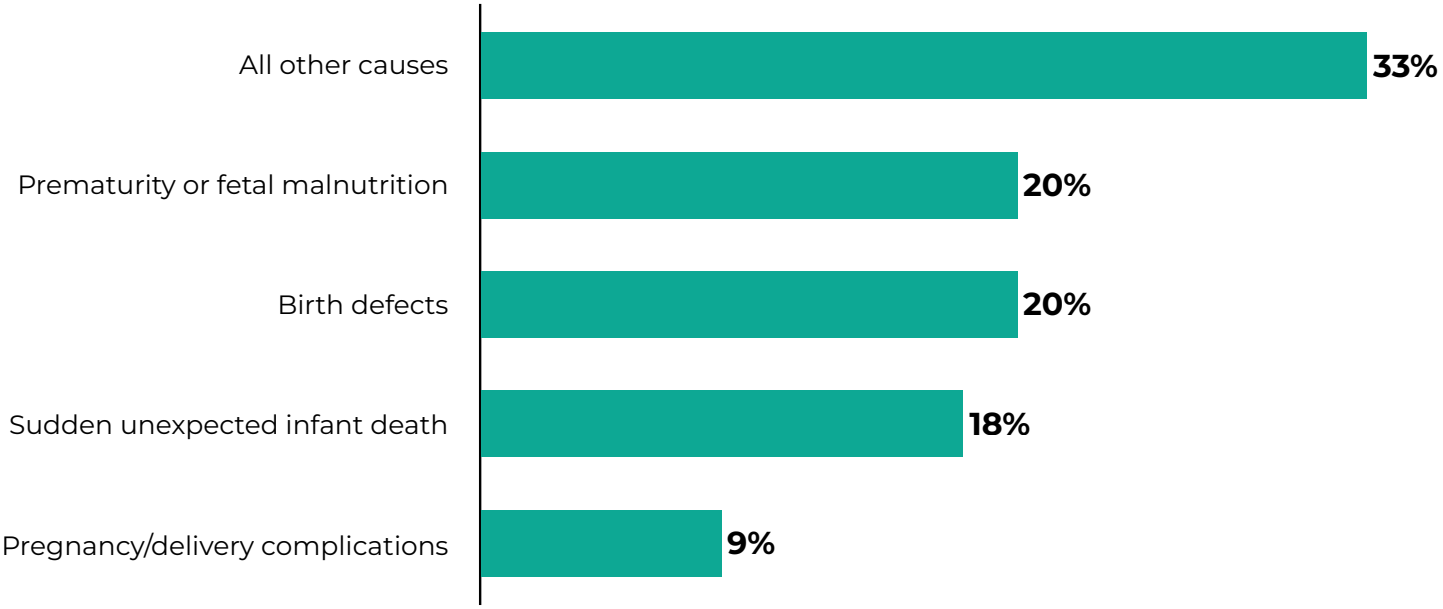
Source: (Centers for Disease Control and Prevention, 2024p)



Approximately two-thirds of all infant deaths occur within the first four weeks of life. Analyzing when infant deaths occur can help focus intervention strategies for maximum impact, as these trends have remained stable since 2012 (Illinois Department of Public Health, 2024e).

Figure 156.

Chart of leading causes of infant death as a percentage of total infant deaths in Illinois, 2021



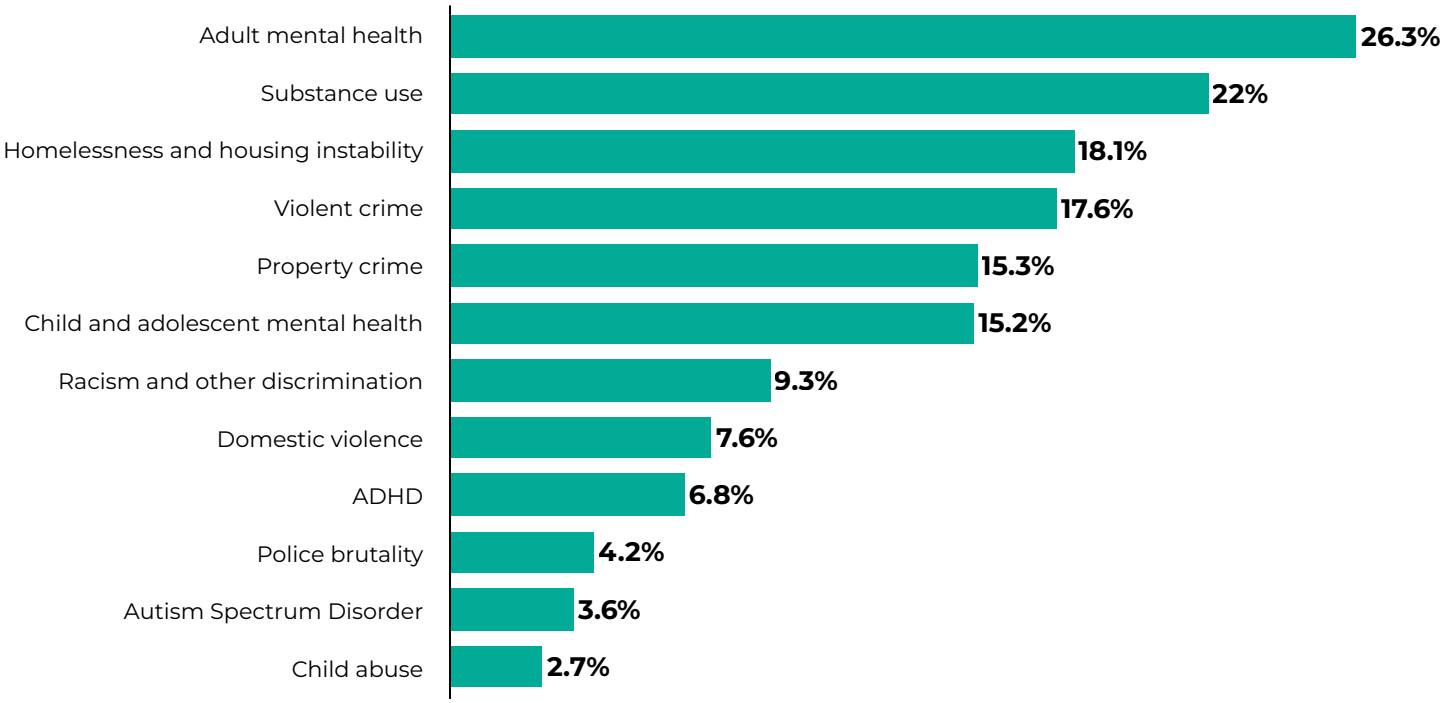
Source: (Bennet et al., 2023)

MENTAL HEALTH

Mental health is an integral and essential component of overall health and well-being (World Health Organization, 2022). Mental health includes emotional, psychological, and social well-being, and it affects how we think, feel, and act. In addition, it influences how a person handles stress, relates to others, and makes healthy choices (Centers for Disease Control and Prevention, 2024w).
The countywide community input survey asked respondents to rank the top three biggest health issues in their community. Adult mental health was the number one concern with 26% of respondents ranking it in their top three (Figure 157). Substance use was third highest with 22% and child and adolescent mental health garnered 15% (Figure 157).

Figure 157.

Survey responses – Mental health-related top health issues



Focus group participants also raised numerous concerns related to mental health. They discussed the widespread impact of untreated mental health conditions, often linked to systemic barriers such as poverty, stigma, and inadequate healthcare access. Depression, anxiety, Post-Traumatic Stress Disorder, Autism, ADHD, and bipolar disorder were all specifically mentioned as concerns. Participants emphasized the need for culturally relevant mental health services and better education on mental wellness.

NON-MEDICAL FACTORS AFFECTING MENTAL HEALTH (SOCIAL DETERMINANTS OF MENTAL HEALTH)

Mental health conditions are only one aspect of mental health. Good mental health also includes overall well-being and the ability to thrive (Centers for Disease Control and Prevention, 2024w). There are several factors that influence mental health including:

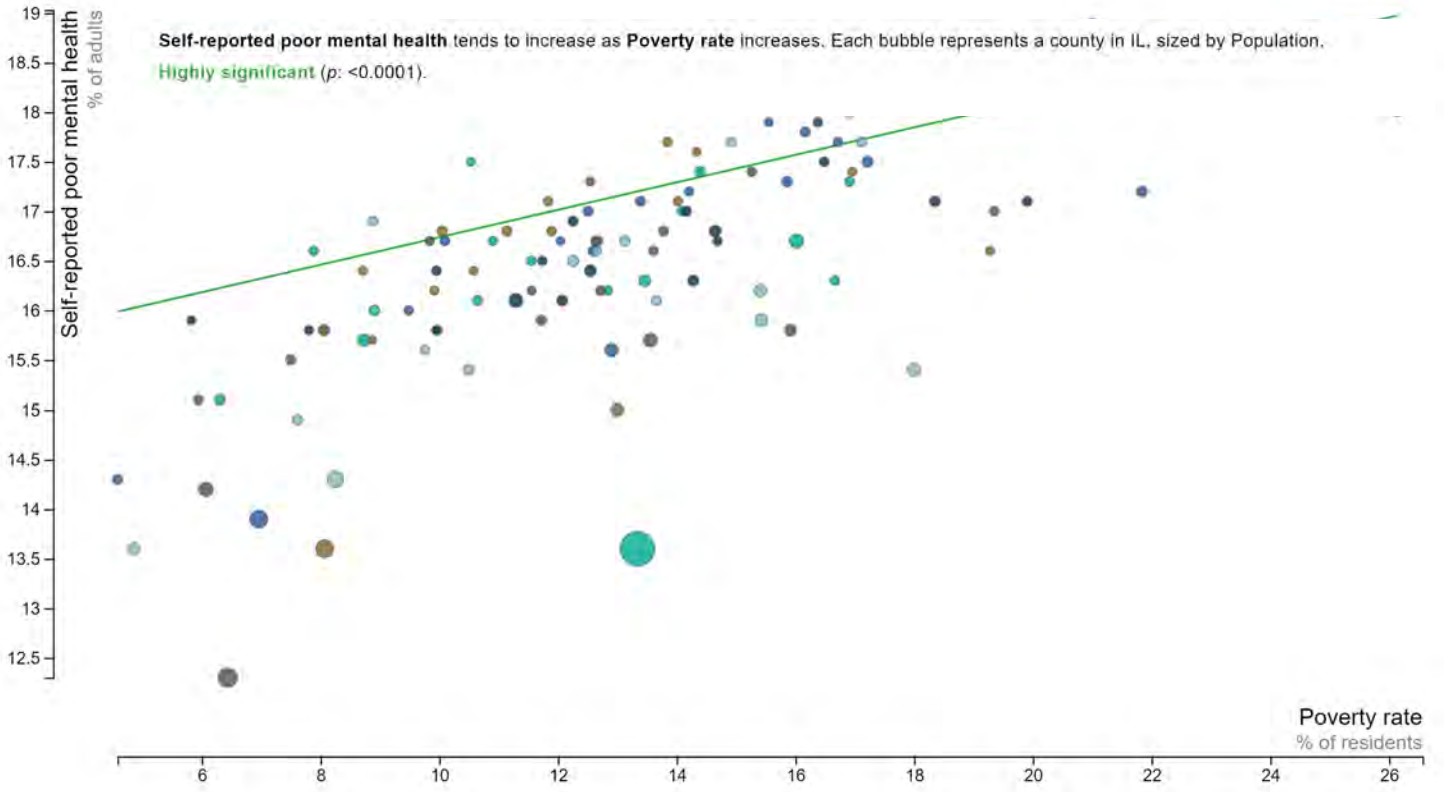
- **demographic factors** such as age, ethnicity, gender, and genetics (Lund et al., 2018; Shim & Compton, 2020).
- **economics** including economic inequity, economic recession, income, debt, assets, financial strain, unemployment, and food insecurity (Lund et al., 2018; Shim & Compton, 2020). Community members also cited housing instability as a factor in mental health.
- **neighborhood** infrastructure, neighborhood environment, built environment, safety and security, housing, overcrowding, and recreation spaces (Lund et al., 2018; Shim & Compton, 2020). Community members emphasized feelings of community safety and transportation as major contributors to mental health.
- **environmental** events such as natural and human-made disasters, war or conflict, climate change, and forced migration (Lund et al., 2018; Shim & Compton, 2020).
- **social and cultural** elements such as racism, discrimination, community social capital, social stability, social support, social participation, and education (Lund et al., 2018; Shim & Compton, 2020). Community members discussed how social isolation, parenting challenges, and language and cultural barriers affect mental health.
- **trauma and stress** living with chronic stress, adverse childhood experiences, acute trauma, and complex trauma (Lund et al., 2018; Shim & Compton, 2020).

> "Gentrification has really hit us very hard. We don't see our neighborhood as 'it's up and rising, this and that.' Nobody knows the struggles we go through at night. You hear gunshots every week. The other day we were hearing stuff, and my little cousin told me like, 'Oh, I'm used to it'"
>
> — NAMI Metro Suburban focus group participant

A direct link exists between social and economic inequity and mental health (Macintyre et al., 2018). Worldwide, there is a social gradient in mental health with higher levels of income inequity being linked to higher prevalence of mental illness (Macintyre et al., 2018). Socioeconomic disadvantages including unemployment, low income, poverty, debt, and poor housing are consistently associated with poorer mental health (Cairns et al., 2017; Elliot, I, 2016; Macintyre et al., 2018; Shim & Compton, 2020). This trend is apparent in the United States as well, where there is a highly significant correlation between poverty rate and poor self-reported mental health (Figure 158). In addition, mental health conditions are prominent among historically marginalized and systemically excluded populations who experience social exclusion, discrimination, racism, and trauma.

Figure 158.

Chart of the correlation between poor self-reported mental health and poverty rate for counties in Illinois, 2021



Created on Metopio: https://metop.io/i/4t7pe4aq | This was determined to be a highly significant relationship via regression analysis, explaining 66.7% of the variation in the Y axis (R-squared). Source: (Centers for Disease Control and Prevention, 2024q; US Census Bureau, 2024)

Inequities are particularly injurious to the communities that experience them not only because they limit access to services and other resources, but also because the experiences of marginalization and discrimination are traumatic. Research has established that traumatic experiences can cause stress that is toxic to the body and can result in dysregulation, inflammation, and disease. The effects of trauma and toxic stress are detrimental throughout the lifespan but can be particularly deleterious when exposure begins in childhood (Adverse Childhood Experiences, ACEs). As a result, exposure to trauma and the resulting toxic stress contribute to widening health disparities. Supporting and partnering with communities that have experienced trauma to build resiliency is an important step in reducing health inequities, however, it is critical to address the underlying root causes of traumatizing inequities with a focus on future prevention (Shonkoff et al., 2021).

Priority populations

Mental health impacts everyone, however, some populations experience a greater burden of mental health conditions given inequitable distribution of opportunity and resources. During focus groups held throughout Cook County and through reviews of previous studies, several populations were identified as having priority needs related to mental health.

- **Children, adolescents, and young adults** have unique needs related to mental health. Individuals in these developmentally sensitive periods are particularly vulnerable to mental health risk factors such as parental abuse and bullying (World Health Organization, 2022). However, despite continually rising rates of depression, anxiety, suicide attempts, and other mental health conditions, treatment availability in Cook County is severely limited for this age group. Social-emotional developmental delays, trauma, and social isolation resulting from the pandemic worsened mental health outcomes among youth.

- **Immigrants and refugees** face unique challenges related to issues such as relocation, forced migration, war and conflicts, social isolation, racism, and discrimination. In addition, they face additional barriers to treatment including lack of insurance coverage, poor access to affordable services, discrimination by medical staff, language barriers, and stigma.
- In 2020, more than one-third of **LGBTQIA+** Americans, including three in five transgender Americans, faced discrimination of some kind (Gruberg et al., 2020). Discrimination adversely impacts mental and economic well-being of many LGBTQIA+ Americans, with 50% reporting moderate or significant psychological impacts (Gruberg et al., 2020).
- **Older adults and homebound adults** have unique mental health needs. Age-related illnesses such as dementia and Alzheimer's Disease were identified as one of the top health needs among community input respondents. In addition, older adults were identified by focus group participants as being more likely to experience isolation. The health risks associated with isolation are particularly severe among the older adult population (World Health Organization, 2023b).
- Although more than 40% of **veterans** have an identified mental health need, more than half do not seek care (National Academies of Sciences, Engineering, and Medicine, 2018).
- The number of individuals with mental health conditions **involved in the juvenile and criminal justice systems** continues to increase (Mental Health America, n.d.-b). The lack of appropriate and culturally competent community-based services has enormous fiscal, health, and human costs (Mental Health America, n.d.).
- **Low-income individuals** and families who struggle to afford out-of-pocket expenses are vulnerable to changes in program funding and closures of public mental health centers.

In 2023, one in five American adults experienced symptoms of anxiety or depression, and two in five high school students reported feelings of hopelessness or sadness (Centers for Disease Control and Prevention, 2024w). Federal, state, and local governments have recognized a mental health crisis in the United States, putting forward funding and political will to address the issue (Centers for Disease Control and Prevention, 2024w).

COVID-19 pandemic

The COVID-19 pandemic increased the prevalence of mental health conditions while simultaneously reducing available community mental health resources. Many effects of the pandemic including social isolation, illness, economic hardship, and misinformation contributed to increased levels of stress, insomnia, depression, and anxiety (Mayo Clinic Staff, 2024). In Illinois, the percentage of adults who reported significant symptoms of depression or anxiety increased from 11% in 2019 to 25% in 2023 (Cook County Health & Cook County Department of Public Health, 2024). Meanwhile, high rates of burnout and other pandemic related stressors caused many mental health professionals to leave the field and deterred new workers from entering (Cook County Health & Cook County Department of Public Health, 2024).

The continuing mental health consequences of COVID-19 were also brought up by focus group participants. The pandemic exacerbated anxiety, depression, and stress due to isolation, fear of illness, and loss of loved ones, especially among older adults, adolescents, young adults, and individuals living alone. Participants reported heightened levels of anxiety, depression, and social awkwardness post-pandemic. The sudden halt of in-person interactions and reliance on virtual connections disrupted social skills and emotional well-being.

Stigma

Stigma is made up of negative stereotypes, prejudices, and discrimination around a certain condition or characteristic (Ahad et al., 2023). The effect of stigma on mental health is multifaceted. Stigma related to racism or other discrimination can affect mental health through isolation, abuse, or denial of housing, educational, or economic opportunities (Sparks, 2020). In addition, stigma around mental health problems can cause individuals to avoid seeking care or support, further worsening mental health (Centers for Disease Control and Prevention, 2024w).

Increased awareness of mental health struggles as a result of the pandemic has helped to lessen, but not eliminate, mental health stigma. Many effective public and personal health initiatives have been created to help reduce stigma and normalize mental health struggles through dispelling misinformation, increasing visibility, and sharing personal stories (American Psychiatric Association, 2024b).

Stigma around mental health, particularly in Black/African American and immigrant communities, was seen by community members as a major barrier to seeking help. Focus group participants noted that many people avoid acknowledging their mental health issues due to fear of judgment.

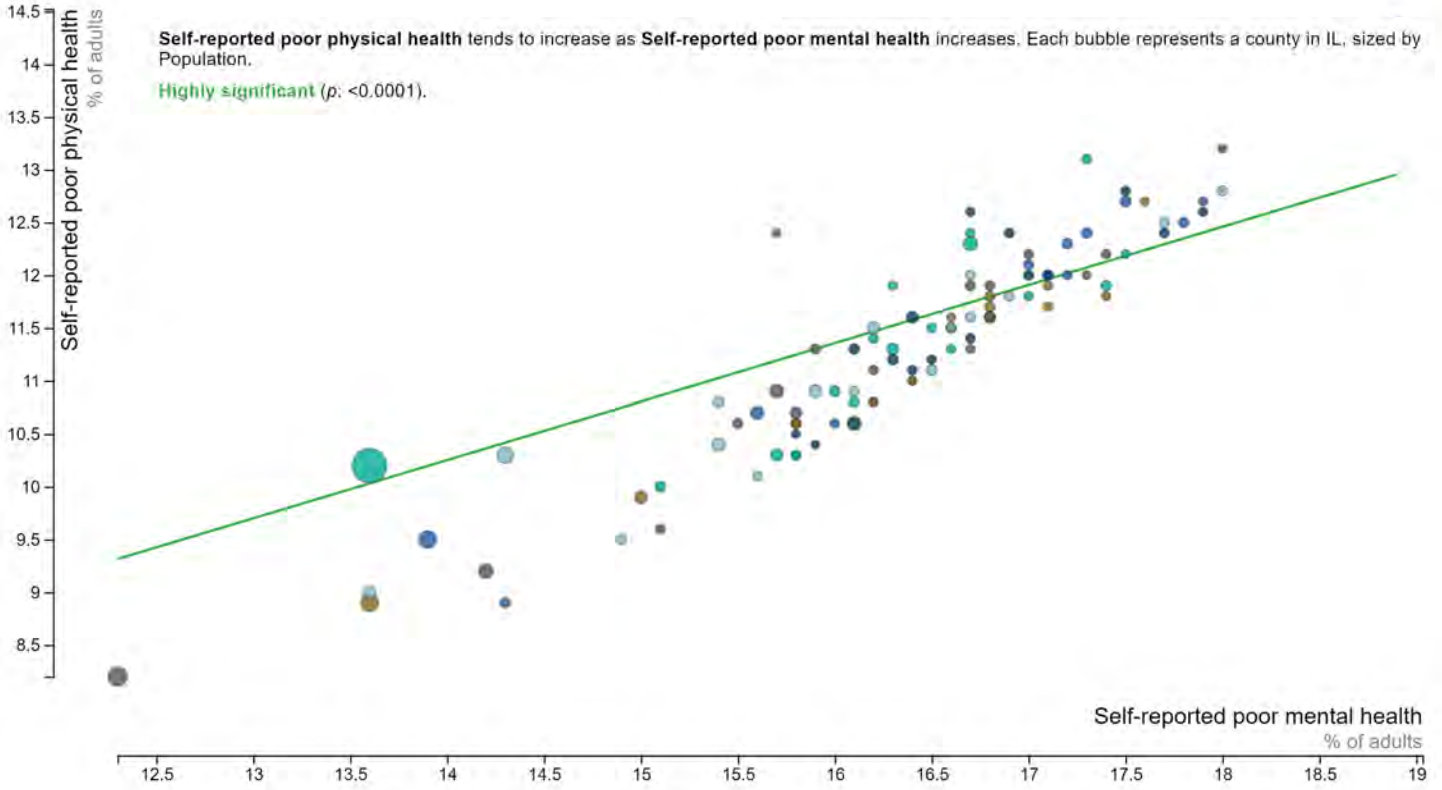
> "Mental illness is real and it will kill you if you don't reach out and get help...talk about it."
>
> — NAMI Metro Suburban focus group participant

MENTAL HEALTH AND OVERALL WELLNESS

Mental health is a major component of overall health and is closely linked to physical health. Addressing both mental and physical health needs are necessary to improve wellness (Centers for Disease Control and Prevention, 2024w). Mental illness significantly increases the risk that an individual will experience a physical health problem, and vice versa. Figure 159 shows the highly significant correlation between poor self-reported mental health and poor self-reported physical health among adults in Illinois. As a result, policies and programs aimed at promoting physical health should include strategies that address both mental health and the underlying root causes of mental and physical health outcomes.

Figure 159.

Chart of correlation between poor self-reported mental health and poor self-reported physical health for counties in Illinois, 2021



Created on Metopio: https://metop.io/i/2h9kqm63 I This was determined to be a highly significant relationship via regression analysis, explaining 92.3% of the variation in the Y axis (R-squared). Source: (Centers for Disease Control and Prevention, 2024q)

MENTAL HEALTH STATUS

While maintaining good mental health is important throughout life, poor mental health affects individuals differently at different stages leading to unique struggles and vulnerabilities.

Adults

In 2022, adults in Cook County reported an average of 5.2 days of poor mental health out of the last 30 days, and 15% of adults reported 14 or more days of poor mental health (County Health Rankings, National Center for Health Statistics, 2024). The prevalence of depression in Cook County adults was 17.5% in 2022, less than both the Illinois (19.4%) and United States (22.5%) (Figure 161).

Figure 160.

Table of self-reported frequency of poor mental health in the last 30 days among adults in Cook County, Illinois, 2022

	COOK COUNTY	ILLINOIS	UNITED STATES
Days of poor mental health	5.2	4.5	5.1
Percent reporting 14 or more days of poor mental health	15%	14%	16%

Source: (County Health Rankings, National Center for Health Statistics, 2024)

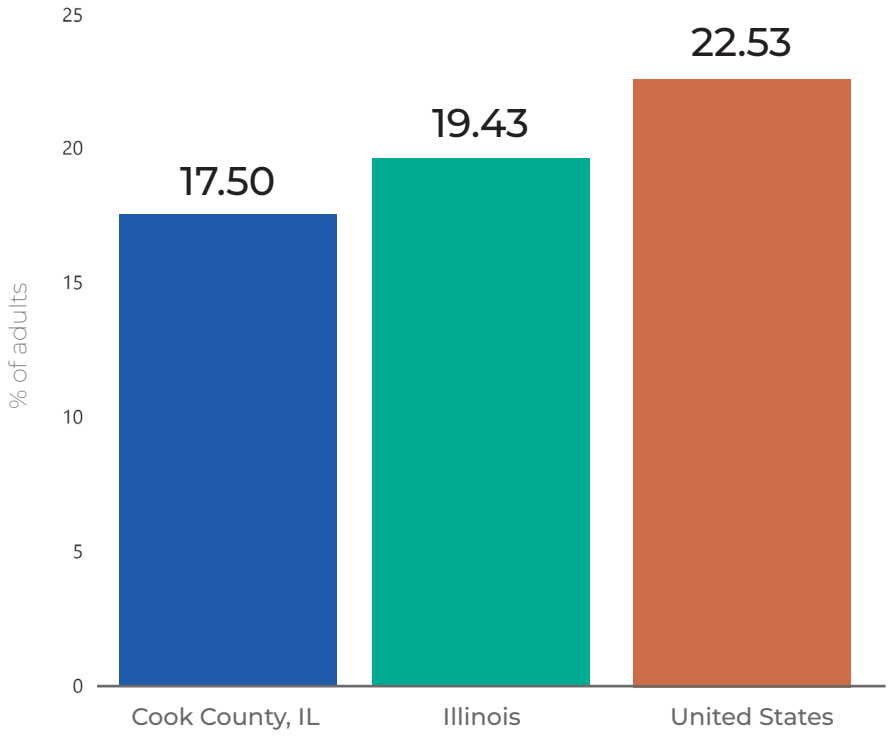


Figure 161.

Chart of adult depression rate as a percentage of adults for Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

Older adults

Older adults are especially vulnerable to mental health conditions due to many factors including poverty, the potential for caretaker abuse, the high prevalence of chronic conditions and disabilities, and increased loneliness and social isolation (World Health Organization, 2023b). Older adults were particularly affected by the COVID-19 pandemic. In 2021, one in five older adults reported their mental health was worse during the pandemic (Gerlach, 2021). Reports of feeling socially isolated went from 27% in 2018 and peaked at 56% in 2021, lessening to 34% in 2023 but not returning to pre-pandemic levels (Figure 162). In 2023, 14% of older adults in Illinois reported being told by a health professional that they have a depressive disorder (Centers for Disease Control and Prevention, 2023a). In 2021, the suicide mortality rate for older adults was 9.3 per every 100,000 deaths in Cook County (Centers for Disease Control and Prevention, 2024o). From 2020-2021, 18.9% of deaths by suicide were older adults in Illinois (Mason, 2024).

In focus groups, stress, depression, and social isolation were recurring themes among adults and older adults, exacerbated by financial instability and caregiving responsibilities.

Figure 162.

Table of social isolation among older adults as a percentage of older adults in the United States, 2018-2023

PERCENT OF OLDER ADULTS WHO REPORT...	2018	2020	2023
Feeling isolated	27%	56%	34%
Lack of companionship	34%	41%	37%
Infrequent social contact	28%	46%	33%

Source: (Malani, 2023)

Youth

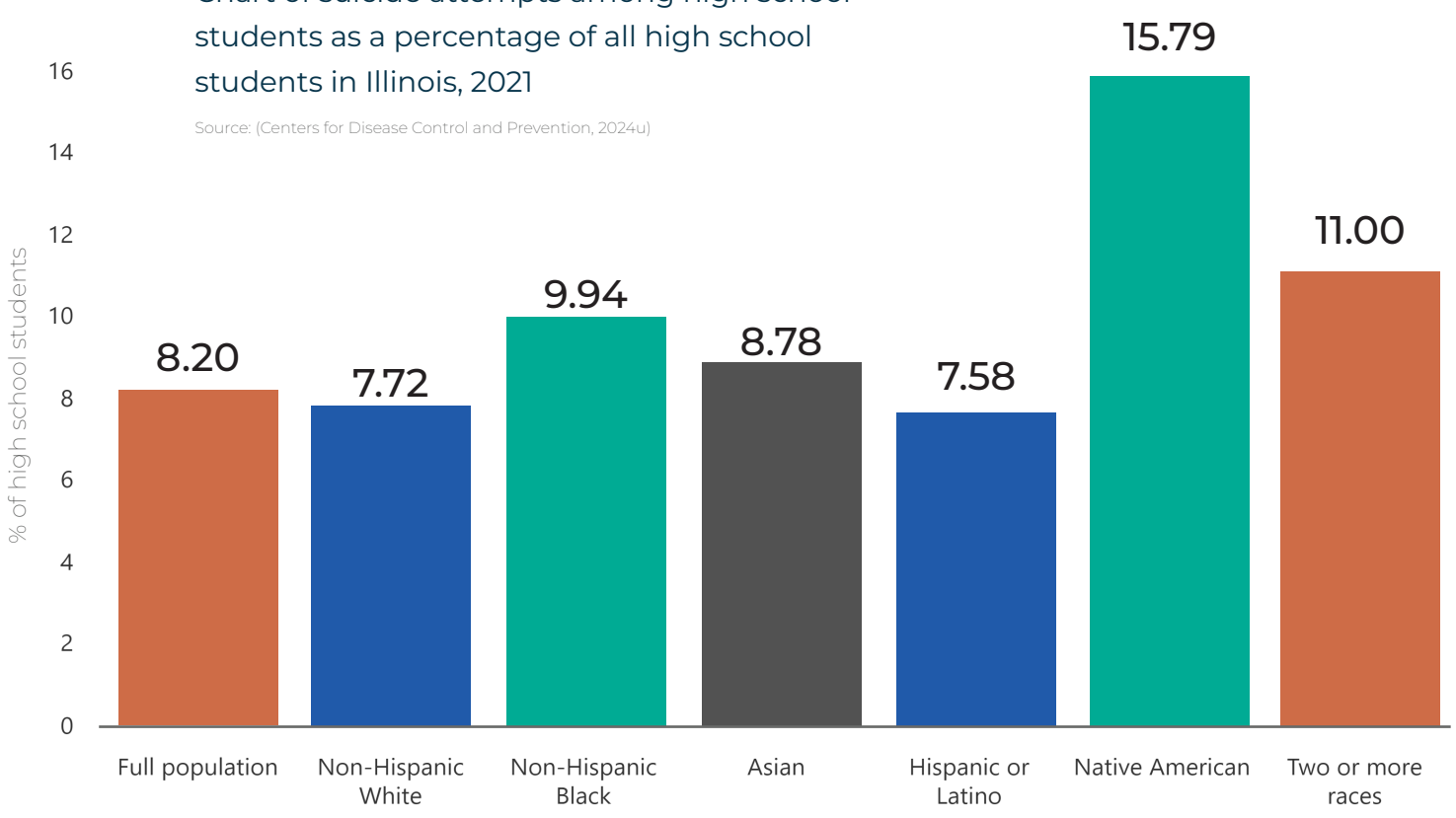
Depression and other mental health conditions in youth can have long-lasting effects. High school students with depression are twice as likely to drop out than their peers, and seven out of 10 youth in the juvenile justice system have a mental health condition (National Alliance on Mental Illness, 2021).

Following the same trends as adults, self-reported depression among youth has been increasing over time and accelerated during the pandemic. It is estimated that pediatric depression and anxiety doubled during the pandemic (Slomski, 2021). This increased the need for already stressed mental healthcare systems. In 2021, 61.8% of Illinois youth with depression did not receive any care (National Alliance on Mental Illness, 2021). Limited and reduced resources resulted in an increase in emergency department visits for youth suicide attempts. When looking at 22 months in 2019-2021, among Illinois youth aged 5-19, emergency department visits for suicide increased by 59% compared to a similar period in 2016-2017 (Jenco, 2022). In 2023, 12.3% of American youth aged 12-17 had serious thoughts of suicide, 5.6% made a suicide plan, and 3.3% attempted suicide (Substance Abuse and Mental Health Services Administration, 2023). There are significant existing inequities in suicide attempts by race and ethnicity with Illinois Native American youth having the highest burden in 2021 (Figure 163).

Figure 163.

Chart of suicide attempts among high school students as a percentage of all high school students in Illinois, 2021

Source: (Centers for Disease Control and Prevention, 2024u)



Focus group participants described youth as particularly vulnerable to poor mental health. Anxiety, depression, and other mental health issues among young people were commonly mentioned. Participants linked these concerns to academic pressures, social media, and lack of support systems. LGBTQIA+ youth face unique challenges such as finding inclusive support spaces and navigating mental health concerns related to identity and transition.

SOCIAL ISOLATION

Social-emotional support and social connectedness are important determinants of mental health that can increase resilience (World Health Organization, 2022). The importance of resilience was highlighted during the pandemic, when stay-at-home orders, social distancing, and other restrictions increased levels of social isolation and 25% of American adults reported increased levels of loneliness (American Psychiatric Association, 2024a).

Social isolation is a risk factor for physical health problems as well, increasing the risk for heart disease, stroke, type 2 diabetes, and dementia (Centers for Disease Control and Prevention, 2024x). Forty two percent of adults in Illinois report a lack of social-emotional support and 39% report frequent feelings of loneliness (Figure 164). In Chicago, 30.4% of adults report feelings of loneliness (Figure 165). The highest rates of loneliness are among Asian and Pacific Islanders (44.0%), and transgender and gender non-conforming individuals (51.6%) (Figure 167). Twenty-eight percent of community input respondents indicated that there were no networks of support for individuals and families during times of stress and need. Focus group participants frequently mentioned isolation and loneliness, particularly among young adults, older adults, and LGBTQIA+ individuals. A lack of inclusive and safe social spaces was seen as a significant barrier to building connections and fostering community cohesion.

Figure 164.

Table of social isolation as a percentage of adults in Illinois, 2024

AUG-SEPT 2024	ILLINOIS	UNITED STATES
Lack of social-emotional support	41.9%	41%
Loneliness	38.8%	40.6%

Source: (National Center for Health Statistics, U.S. Census Bureau, 2024)

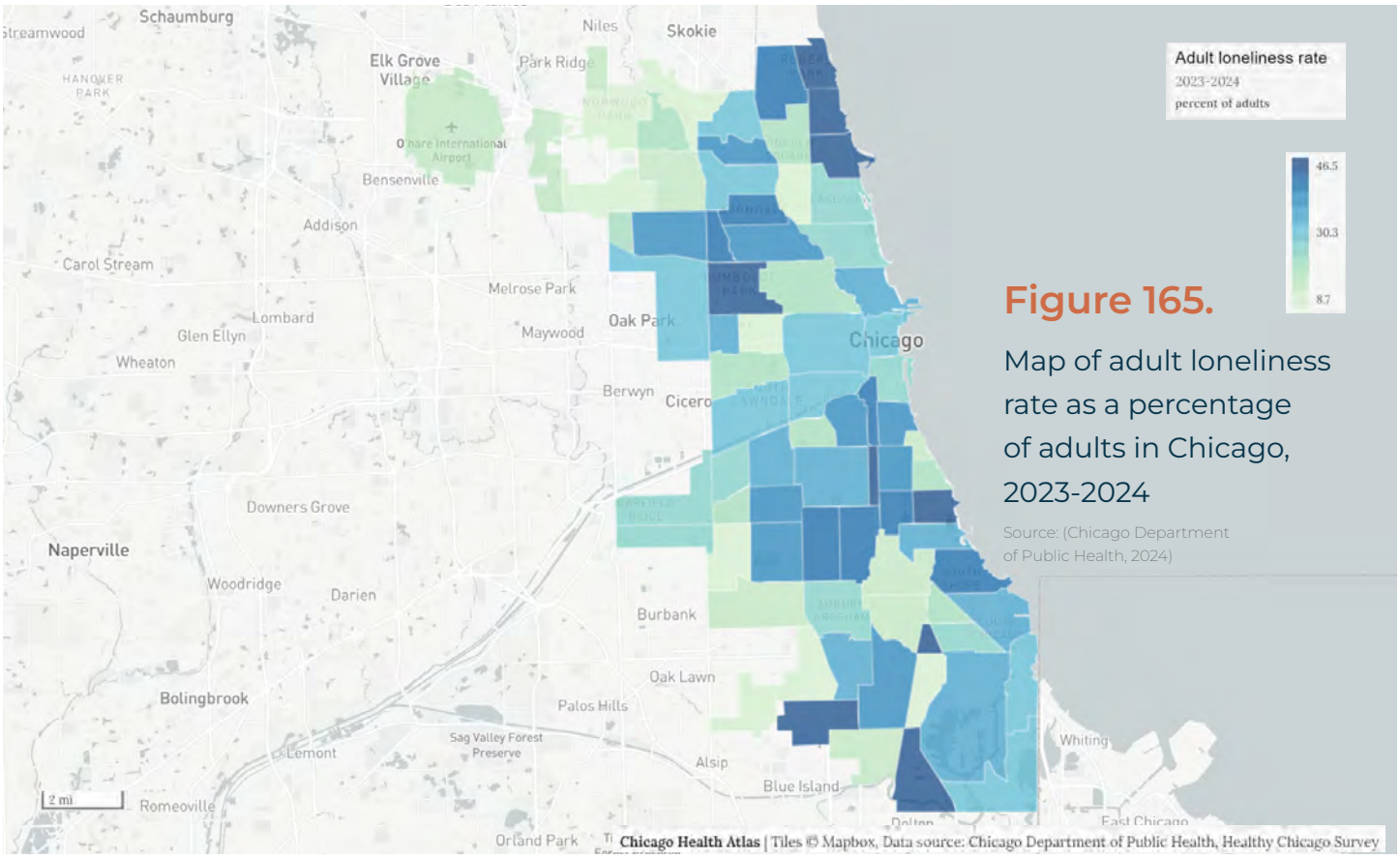


Figure 165.

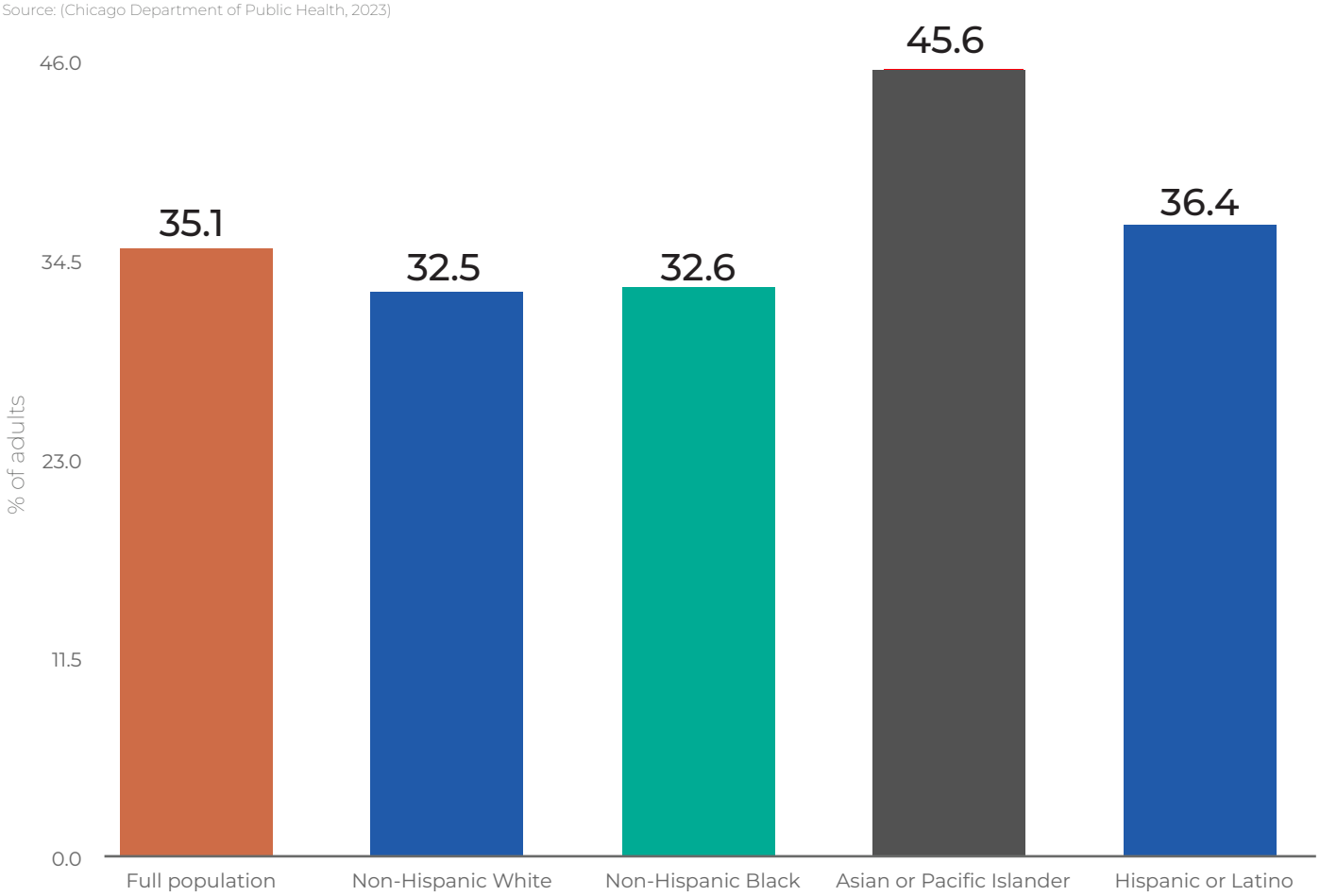
Map of adult loneliness rate as a percentage of adults in Chicago, 2023-2024

Source: (Chicago Department of Public Health, 2024)

Figure 166.

Chart of adult loneliness rate as a percentage of adults by race and ethnicity, Chicago, 2023

Source: (Chicago Department of Public Health, 2023)



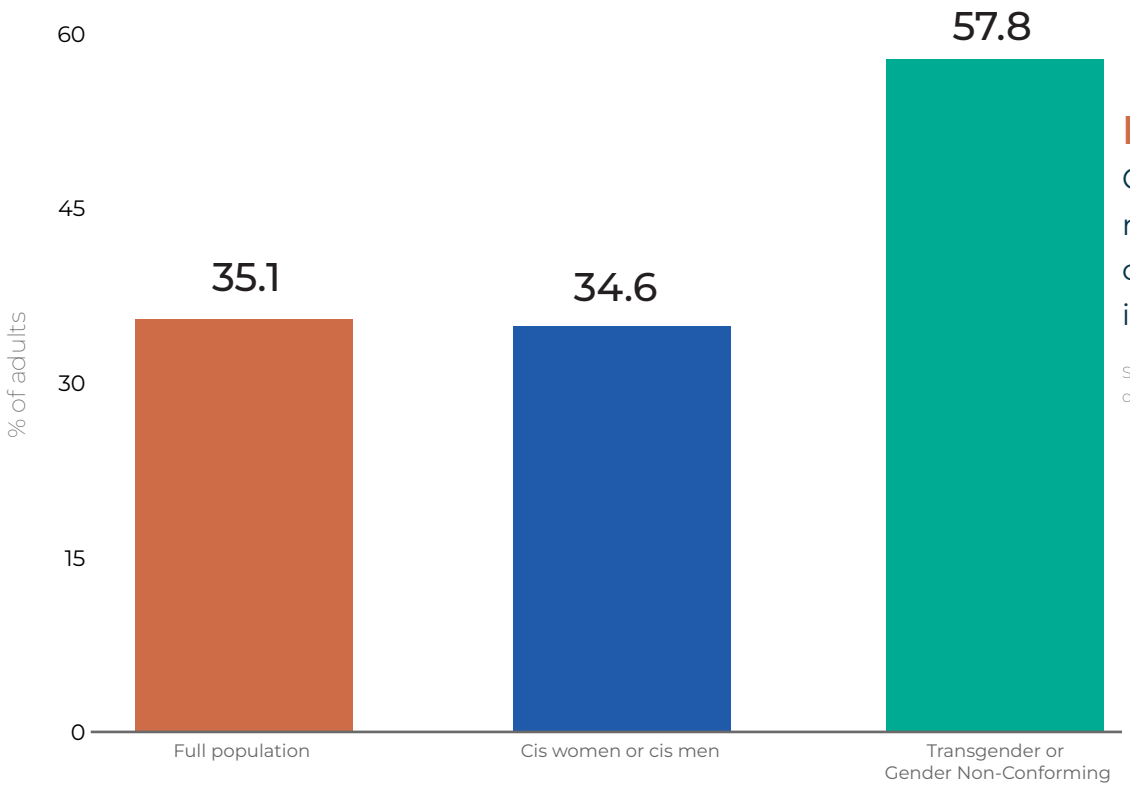


Figure 167.
Chart of adult loneliness rate as a percentage of adults by gender identity, Chicago, 2023

Source: (Chicago Department of Public Health, 2023)

MENTAL HEALTH OUTCOMES AND TREATMENT

Access to treatment

The disparity between the availability of treatment in mental and physical health is widening (Sky et al., 2023). Increasing prevalence of mental health problems and pandemic era resource reductions have caused increased strain on the mental health system, with 38% of Illinois residents living in a Federally Designated Behavioral Health Workforce Shortage Area (Cook County Health & Cook County Department of Public Health, 2024). As of 2024, Cook County is 15,885 workers short of meeting the demand for services (Cook County Health & Cook County Department of Public Health, 2024), creating a dearth of accessible, affordable, culturally competent mental health services. In 2022, the prevalence of Illinois adults with untreated mental illness was estimated to be 53% or 958,000 individuals (National Alliance on Mental Illness, 2023). The consequences of untreated mental illness are staggering for both individuals and society, resulting in unnecessary disability, unemployment, homelessness, substance abuse, inappropriate incarceration, suicide, poor health outcomes, and poor quality of life (National Alliance on Mental Illness, 2023). Inequities in mental health treatment are estimated to cost the United States $477.5 billion in 2024 and reach $14 trillion by 2040 (Dawes et al., 2024).

Community members described significant barriers to accessing mental healthcare, including difficulty finding in-network providers, long wait times for appointments, lack of nearby facilities (particularly in under resourced communities), and inadequate Medicaid coverage for day programs or residential care. The closure of mental health clinics and a lack of crisis intervention services compound access-related issues. Community members described a lack of preventive mental health interventions, with most care being accessed only during crises. Limited local facilities and the need to travel long distances for services were significant obstacles, especially for residents without reliable transportation. Participants also highlighted the absence of trauma-informed care in emergency settings, citing the Cook County Jail as a major mental health facility, reflecting systemic gaps in community-based care.

> "And I would say too that when you're incarcerated, whether it's the Cook County jail or whether you're in a prison, you're limited with resources of mental health. People that are incarcerated, a lot of times they need mental health. You know they're not a criminal. They just make some bad choices. So, I think being able to have those conversations about can we start bringing more resources."
>
> — NAMI Metro Suburban focus group participant

Preventable emergency department visits and hospitalizations

When appropriate community-based treatment is not available, those experiencing serious mental health complications are often forced to seek care in emergency departments (ED) which are often ill-equipped to treat patients promptly and lack the tools to effectively connect them to long-term care (Kalter, 2019). Due to limited access to other healthcare resources, rates for mental health-related ED visits for Black residents are more than double that of white and Hispanic residents. Mental health-related hospitalization rates are also significantly higher among Black residents than white or Hispanic residents (Figure 168). ED visits related to mental health disparities cost the United States an estimated $5.3 billion in 2024 and is expected to reach $17.5B by 2040 (Dawes et al., 2024).

Figure 168.

Table of mental health-related emergency department visit rate and hospitalization rate per 10,000 residents by race and ethnicity, Cook County, Illinois, 2022

	MENTAL HEALTH-RELATED EMERGENCY DEPARTMENT VISIT RATE (PER 10,000 RESIDENTS)		MENTAL HEALTH-RELATED HOSPITALIZATION RATE (PER 10,000 RESIDENTS)	
	COOK	IL	COOK	IL
White	14.07	19.4	40.1	41
Black	35.8	39.1	67.4	67.1
Hispanic	11.7	12.1	29.3	26.2
Total	18.7	21.2	47.7	46.1

Source: (Illinois Department of Public Health, 2022b)

Suicides

Without effective, accessible treatment, poor mental health can escalate to self-harm and suicide. In 2023, 13.1 million American adults had serious thoughts of suicide, 3.7 million made a suicide plan, and 1.5 million attempted suicide (Substance Abuse and Mental Health Services Administration, 2023). For every 100,000 people in Illinois, in 2021, there were 90.5 emergency department visits and 30.2 people were hospitalized for intentional self-harm (Figure 169). In 2022 alone, self-harm-related emergency department visits, hospitalizations, and deaths in Illinois cost more than $30 billion (Illinois Suicide Prevention Alliance, 2023).

Figure 169.

Table of self-harm related emergency department visit rate and hospitalization rate per 100,000 population, Illinois, 2017-2021

ILLINOIS	2017	2019	2021
Self-harm hospitalization rate per 100,000 population	37.3	33.5	30.2
Self-harm ED visit rate per 100,000 population	89.3	85.2	90.5

Source: (Illinois Suicide Prevention Alliance, 2023)

From 2023 to 2024, preliminary counts of death by suicide in Cook County show a decrease of 15% (Figure 170). In 2024, white individuals made up the largest percentage of suicide mortality at 61% followed by Black individuals at 17% (Figure 170), and 80% of suicide deaths were male (Figure 171).

Figure 170.

Table of suicide mortality rate as a percentage of all suicide deaths by race and ethnicity, Cook County, Illinois, 2023-2024

	TOTAL SUICIDES	BLACK	LATINO	WHITE	ASIAN	OTHER
2023	508	20%	16%	59%	4%	<1%
2024	431	17%	16%	61%	5%	<1%

Source: (Cook County Medical Examiner's Office, 2025b)

Figure 171.

Table of suicide mortality rate as a percentage of suicide deaths by sex, Cook County, Illinois, 2023-2024

	MALE	FEMALE
2023	78%	22%
2024	80%	20%

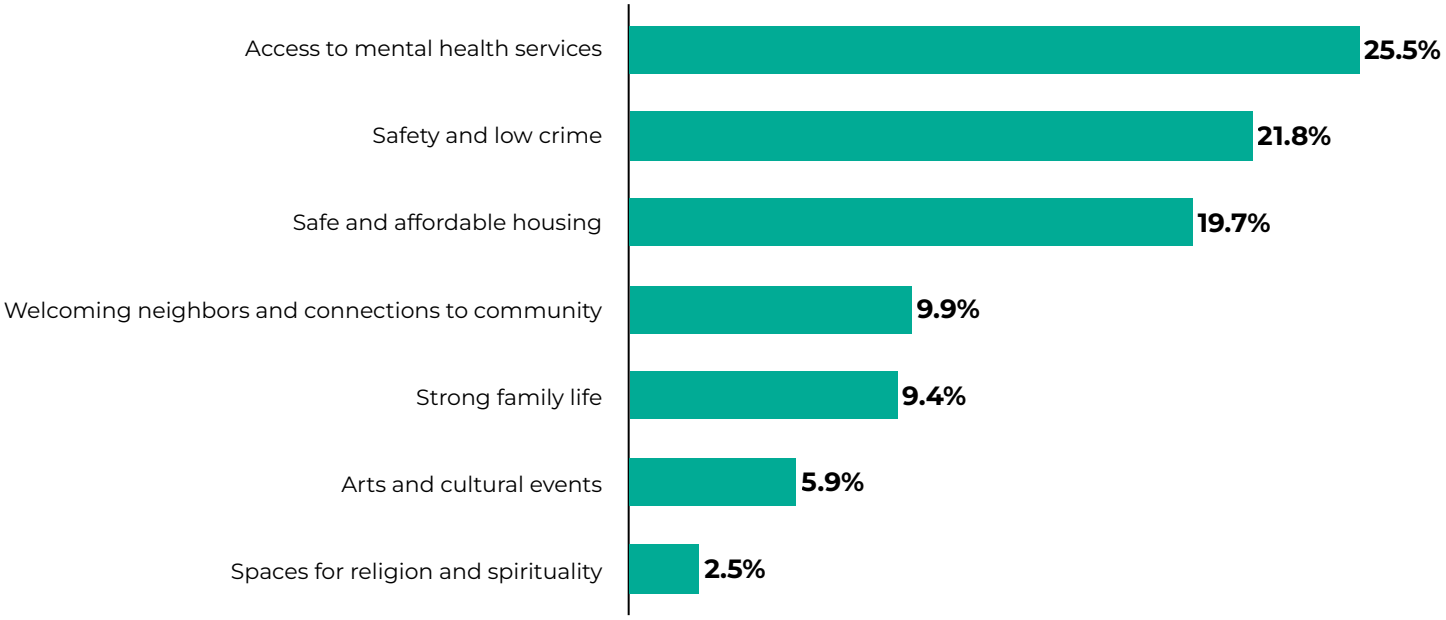
Source: (Cook County Medical Examiner's Office, 2025b)

Solutions

When asked about the top three things their community needs to be healthy, survey respondents selected several aspects related to mental health. The top response was the "ability to access mental healthcare services in a reasonable amount of time" with 26% of respondents ranking it in their top three (Figure 172).

Figure 172.

Survey responses – Mental-health related top health needs



Community-based interventions
Many community-based solutions addressing mental health and wellness were discussed in the focus groups.

Figure 173.

Part 1 of 2. Table of community suggested solutions to community mental health issues

THEME	SUMMARY
Address social determinants of health	Hospitals were encouraged to invest in programs addressing housing instability, food insecurity, and economic opportunities as part of a comprehensive approach to health.
Tackling stigma and cultural barriers	Participants identified stigma around mental health and healthcare as a barrier to seeking help. They proposed community-driven campaigns to normalize discussions about mental health and to educate residents about the benefits of seeking care. In addition, respondents advocated for culturally relevant healthcare services that respect the diverse backgrounds of Cook County residents.
Youth mentorship and guidance	Foster mentorship opportunities for personal and professional growth. Specific examples include Boys and Girls clubs and programs like UI Health CHAMPIONS.
Strengthening community ties	Many highlighted the importance of fostering a strong sense of community. This included creating safe, accessible gathering spaces, supporting local organizations, and promoting activities that encourage social interaction. Addressing feelings of isolation, especially among seniors and marginalized groups, was seen as essential to improving mental and physical health.
Improving access to care	Participants emphasized the need for better access to high-quality healthcare services, including mental healthcare, substance abuse programs, and specialized care for vulnerable populations like youth, older adults, and people experiencing homelessness.

Figure 173.

Part 2 of 2. Table of community suggested solutions to community mental health issues

THEME	SUMMARY
Enhance access to mental health services	• Increasing the availability of licensed mental health professionals: Participants expressed difficulty in accessing licensed therapists and called for hospitals to hire more professionals to address gaps in mental health services. • Providing holistic care for priority populations: Suggestions included integrating mental health services with care for the homeless and those struggling with substance abuse. • Community-based care: Invest in mental health infrastructure, including outpatient clinics, telehealth services, and crisis intervention programs. • Crisis care: Enhance emergency care and crisis intervention services for mental health and substance abuse issues.
Address structural and policy barriers	• **Reducing bureaucratic challenges**: Simplifying administrative processes, such as insurance and eligibility verifications, to make hospital services more accessible. • **Emergency support systems**: Participants suggested hospitals could invest in systems to ensure rapid access to care during crises, such as instant clinics for urgent needs.
Workforce development	There were mentions of hospitals investing in local workforce development, particularly in creating job opportunities and training programs for residents. This aligns with the broader goal of economic empowerment in the community. • **Training programs:** Investment in training programs to recruit and retain healthcare workers from diverse backgrounds, reflecting the communities they serve. Including establishing partnerships with local schools, colleges, and vocational programs to create pipelines for future healthcare workers • **Continuing education:** Providing continuing education and certifications for existing staff in areas such as cultural competency, trauma-informed care, and advanced clinical skills.
Mental health and trauma support	Offer accessible mental health services to address trauma stemming from exposure to violence, fostering healing and resilience within communities.

> “I say you start in a school. That’s the best place to start. Having a part of the curriculum, you know what I’m saying? Like, make it so that people are aware. Because I went to a high school, we talked about mental health for like two months, and then that was it. But, if I would have started earlier, I would have known that maybe I do got some people I need to talk to. Maybe I can, you know, have somebody I can talk to. Mentorship is definitely important. Very important, knowing that it’s okay to go through something and ask somebody to talk to you.”
>
> — NAMI Metro Suburban focus group participant

SUBSTANCE USE DISORDERS

A substance use disorder is a complex condition in which there is uncontrolled use of a substance despite harmful consequences, and day-to-day functioning becomes impaired (Torrise, n.d.). Substances can include alcohol, nicotine, marijuana, and other drugs such as sedative-hypnotics or barbiturates, opiates, sedatives, hallucinogens, and psychostimulants (Mental Health America, n.d.-a). In 2023, 48.5 million Americans had a substance use disorder, 2.2 million of which were between the ages of 12-17 (Substance Abuse and Mental Health Services Administration, 2023).

The countywide community input survey asked respondents to rank the top three biggest health issues in their community. Adult mental health was the number one concern with 26% of respondents ranking it in their top three (Figure 157). Substance use was third highest with 22% and youth mental health had 15% (Figure 157).

Focus group participants shared significant concerns regarding substance use disorders and their impact on individuals and communities. Participants described the physical and mental toll of substance abuse on individuals, including health crises and struggles with addiction recovery. Populations highlighted as experiencing specific challenges included youth and people experiencing homelessness.

Substance use disorders were described as having far-reaching effects, including increased rates of crime, strained family relationships, and higher demand for emergency medical services. They were repeatedly tied to increasing violence, including gun violence. Participants noted issues with substance use in public spaces, such as people smoking or using drugs on public transportation and in parks, contributing to a sense of insecurity.

> “There’s so many drugs out there, so many people that are consuming a lot of drugs.”
>
> — NAMI Metro Suburban focus group participant

Contributing factors

- **Biology:** Genetics make up about half of a person’s risk for substance use disorder. Having a mental health condition, sex, and ethnicity are also contributing factors (National Institute on Drug Abuse, 2018).
- **Environment:** A person’s environment can influence their risk for substance use. Poverty, abuse, stress, and exposure to substances can elevate risk (National Institute on Drug Abuse, 2018). For youth, lack of parental involvement, peer substance use, peer rejection, and academic problems can also increase the likelihood of substance use (Centers for Disease Control and Prevention, 2024v). Community members pointed to easy and early exposure to substances as well as the connection between homelessness and substance use.
- **Development:** Early drug use can interfere with development of decision-making, judgement, and self-control, making it more likely that an individual will develop a substance use disorder (National Institute on Drug Abuse, 2018).
- **Mental health:** In 2023, 35% of adults with mental illness reported also having a substance use disorder (Substance Abuse and Mental Health Services Administration, 2023).

Community members linked substance use to untreated mental health conditions, including depression and PTSD, with focus group participants highlighting the cyclical nature of these challenges. High levels of stress due to financial instability, violence, and chronic health conditions were highlighted as contributing to substance use as a coping mechanism.

Youth substance use

Drug and alcohol use in youth can have far reaching consequences. By interfering with the developing brain, those who start using young are more likely to develop substance use disorder (National Institute on Drug Abuse, 2018). This is detrimental to physical and mental health and can lead to criminal justice involvement, dropping out of school, and long-term substance use (Centers for Disease Control and Prevention, 2024v). Despite this, fewer than half of surveyed Suburban Cook County twelfth grade students remember their parents talking to them about not using alcohol (46%) and opioids (32%) (Figure 174).

> “Instead of dealing with the stressors, they turn to things that kind of numb themselves.”
>
> — NAMI Metro Suburban focus group participant

Figure 174.

Table of twelfth grade students who reported their parents had talked to them about drugs in the past year as a percentage of all surveyed twelfth grade students, Suburban Cook County, Illinois, 2024

	YES	NO	DON'T REMEMBER
Not using alcohol	46%	46%	8%
Not using tobacco	39%	51%	9%
Not using marijuana	46%	47%	8%
Not using opioids for non-medical reasons	32%	59%	9%

Source: (Illinois Department of Human Services, 2024a)

In focus groups, community members raised concern about increasing substance use among teenagers and young adults, including vaping, alcohol, and drug experimentation. It was often linked to peer pressure, stress, and lack of structured activities. Some younger participants mentioned increased drug use along with increased arrests related to gun violence and substance use at their schools.

> "For my school specifically, substance abuse is a big thing because once in a while, almost like every week, someone from school gets arrested for gun violence or drug use."
>
> — NAMI Metro Suburban focus group participant

Children and teenagers were highlighted as particularly vulnerable to violence and unsafe environments. Concerns were raised about the lack of safety in and around schools, including bullying and school-based violence. Lack of safe recreational spaces for youth was noted as a contributing factor to their involvement in unsafe behaviors such as gang activity and substance use.

COVID-19 and substance use disorders

The COVID-19 pandemic both highlighted and worsened the increasing burden of substance use disorders in the United States. The percentage of Illinoisans who reported binge drinking more than doubled from 7.9% in 2019 to 18.4% in 2022 (Illinois Department of Human Services, 2020, 2024a).

Figure 175.

Table of reported alcohol and substance use in the past month as a percentage of those surveyed in Illinois, 2018-2022

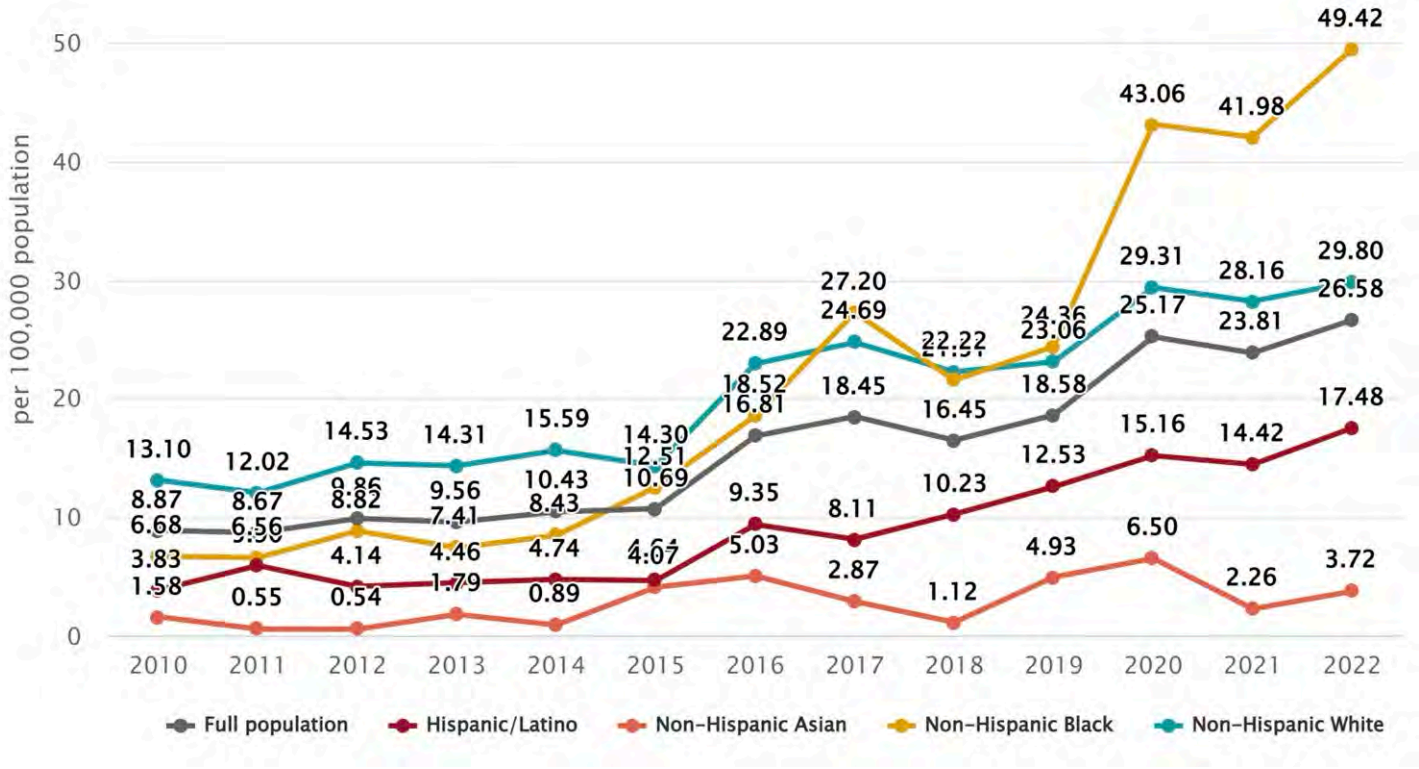
	2018-2019	2021-2022
Reported substance use in the past month, 12+	12.0%	17.2%
Reported substance use in the past month, 18+	12.4%	18.2%

Source: (Substance Abuse and Mental Health Services Administration, 2019, 2022)

A consequence of increased usage during the pandemic was an increase in overdose deaths. In Suburban Cook County, the drug-related mortality rate increased from 18.6 in 2019 to 26.6 in 2022 (Figure 176). There were inequities among groups by race and ethnicity, with the rate for non-Hispanic Black individuals doubling from 24.4 to 49.4 per 100,000 individuals (Figure 176).

Figure 176.

Chart of drug-induced mortality rate per 100,000 population over time by race and ethnicity, Suburban Cook County, Illinois, 2010-2022



Source: (Illinois Department of Public Health, 2024a)

When it comes to youth, the Monitoring the Future study showed that substance use among high school students in the United States has been decreasing since the beginning of the pandemic. The percentage of twelfth grade students who reported not using any substances in the past 30 days increased from 53% in 2017 to 67% in 2024 (Miech et al., 2024).

Opioid epidemic

Before the start of the COVID-19 pandemic, opioid overdose and drug-related deaths were steadily increasing in the city and county. In March 2020, the rates of opioid overdose mortality and drug-related deaths began to skyrocket (Ghose et al., 2022; National Center for Health Statistics, 2021). A major contributor to the increased number of overdoses is the growing prevalence of synthetic opioids like fentanyl, which is 50 times more potent than morphine, making it easier to overdose, especially if the user thinks they are using a less potent drug (National Institute on Drug Abuse, 2022). In Cook County, fentanyl was involved in 87% of overdose deaths in 2024 (Cook County Medical Examiner's Office, 2025b).

In Cook County, preliminary data shows that opioid overdose deaths decreased from 2022 to 2024 after peaking in 2022 (Figure 177). This decrease is partially due to increased availability and awareness of overdose reducing drugs like Naloxone (Narcan) (Liptrot, 2025).

Figure 177.

Table of opioid overdose death count in Cook County, Illinois, 2015-2024

YEAR	OPIOID OVERDOSE DEATHS
2016	1,081
2018	1,170
2020	1,847
2022	2,001
2024	1,026

Source: (Cook County Medical Examiner's Office, 2025b)

TREATMENT

Substance use disorder is treatable. Behavioral therapies like counseling and support groups are a key part of treatment. For some substances, like opioids, nicotine, and alcohol, medication-assisted treatment is becoming more common (National Institute on Drug Abuse, 2020). Medications such as Methadone, Buprenorphine, Lofexidine, and Naloxone can reduce opioid cravings, treat withdrawal symptoms, and reverse overdose (National Institute on Drug Abuse, 2023). However, only 22.7% of American adults and 38.9% of youth who were identified as needing treatment for substance use disorder received treatment in 2023 (Figure 178). Stigma and difficulty accessing services are the two main reasons cited by individuals who did not receive treatment (Figure 179). Stigma among healthcare providers, law enforcement, and regulatory agencies contributes to the difficulty individuals face in accessing treatment (American Psychiatric Association, 2024b). Collaboration between treatment providers and these groups, as well as patient family and friends, is improving patient success. Other treatment types being explored include offering monetary incentives for sobriety and mindfulness-based programs (American Psychiatric Association, 2024b).

Community discussions echoed these findings. Community members cited stigma and a lack of access to resources as major barriers to treatment. A major barrier is the lack of accessible and timely substance use treatment programs, including rehabilitation and counseling services as well as harm-reduction programs. Programs like Roads to Recovery were mentioned but seen as insufficient for the level of need in communities.

Figure 178.

Chart of people that received substance use treatment in the past year as a percentage of people who needed substance use treatment by age in the United States, 2023

Source: (Substance Abuse and Mental Health Services Administration, 2023)

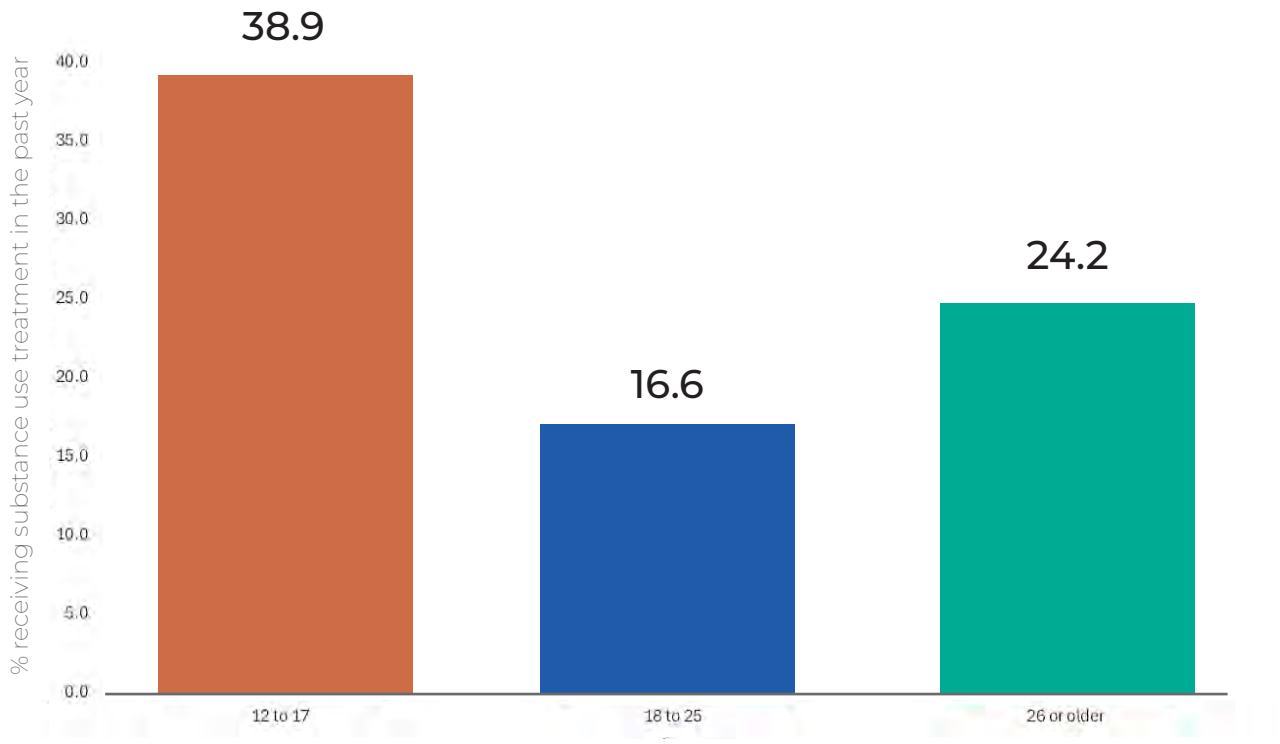


Figure 179.

Part 1 of 2. Table of reasons for not receiving substance use treatment among adults who needed but did not receive treatment in the past year, 2023

REASON FOR NOT RECEIVING SUBSTANCE US TREATMENT	PERCENT
Cost	40.1%
Insurance would not cover it	28.6%
Insurance would not pay enough of the cost	30.7%
Did not know how or where to get treatment	37.1%
Could not find a treatment program or professional they wanted to go to	27.4%
No openings in desired treatment program	13.4%
Problems with transportation, childcare, or getting appointments at times that worked for them	21.9%
Did not have enough time for treatment	39.0%
Worried about privacy	32.4%
Worried about what others would think or say	41.5%
Thought bad things would happen if people knew they were in treatment (lose job, home, children)	30.9%
Not ready to start treatment	62.3%
Not ready to stop or cut back using substances	55.9%
Thought they should have been able to handle their substance use on their own	70.7%

Figure 179.

Part 2 of 2. Table of reasons for not receiving substance use treatment among adults who needed but did not receive treatment in the past year, 2023

REASON FOR NOT RECEIVING SUBSTANCE US TREATMENT	PERCENT
Thought their family, friends, or religious group would not like it if they got treatment	16.7%
Thought they would be forced to stay in treatment or rehab against their will	22.9%
Did not think treatment would help them	24.4%
Thought no one would care if they got better	16.8%

Source: (Substance Abuse and Mental Health Services Administration, 2023)

Racial and ethnic disparities

As with other mental health related conditions, there are inequities around substance use disorder rates and treatment. Race and ethnicity are socially constructed categories that have profound effects on the lives of individuals and communities. Racial and ethnic health inequities are the most persistent inequities in health over time in the United States (Weinstein et al., 2017).

Inequities are particularly injurious to the communities that experience them not only because they limit access to services and other resources, but also because the experiences of marginalization and discrimination are traumatic. Research has established that traumatic experiences can cause stress that is toxic to the body and can result in dysregulation, inflammation, and disease. The effects of trauma and toxic stress are detrimental throughout the lifespan but can be particularly deleterious when exposure begins in childhood (Adverse Childhood Experiences, ACEs). Trauma and stress have been shown to contribute to and worsen substance use disorders (Amaro et al., 2021).

In 2023, 19.1% of Americans needed substance use treatment, with American Indian and Alaskan Natives representing the highest percentage (30.6%) followed by Non-Hispanic Multiracial individuals (26.2%)(Substance Abuse and Mental Health Services Administration, 2023). Of those designated as needing substance use treatment, only 18.9% of Non-Hispanic Black individuals received treatment, compared to 24.2% of non-Hispanic white and 25.3% of Hispanic or Latino individuals (Figure 180).

> “The stigma of the use of drugs is diminishing, and more people are accepting that this is a disease that needs treatment.”
>
> — La Shawn Ford, Illinois State Representative

Figure 180.

Table of individuals 12+ that received substance use treatment as a percentage of individuals 12+ that needed treatment by race and ethnicity in the United States, 2023

RACE AND ETHNICITY	PERCENT WHO RECEIVED TREATMENT
Asian	20.8%
Black	18.9%
White	24.2%
Hispanic or Latino	25.3%
Two or more races	21.5%

Source: (Substance Abuse and Mental Health Services Administration, 2023)

ALCOHOL USE

Alcohol use and alcohol-related substance use disorder is responsible for between 5%-6% of deaths worldwide (National Center for Drug Abuse Statistics, 2023). In 2023, 28.9 million Americans had an alcohol-related substance use disorder (Substance Abuse and Mental Health Services Administration, 2023). In 2022, 21% of adults in Cook County reported excessive drinking (Figure 181), however, alcohol use is likely to be significantly underreported, so this estimate provides a lower bound on actual excessive drinking prevalence. In the United States, excessive alcohol use played a role in 7% of all emergency department visits, 16% of drug overdose deaths, and roughly one in four deaths by suicide (National Institute on Alcohol Abuse and Alcoholism (NIAAA), 2024).

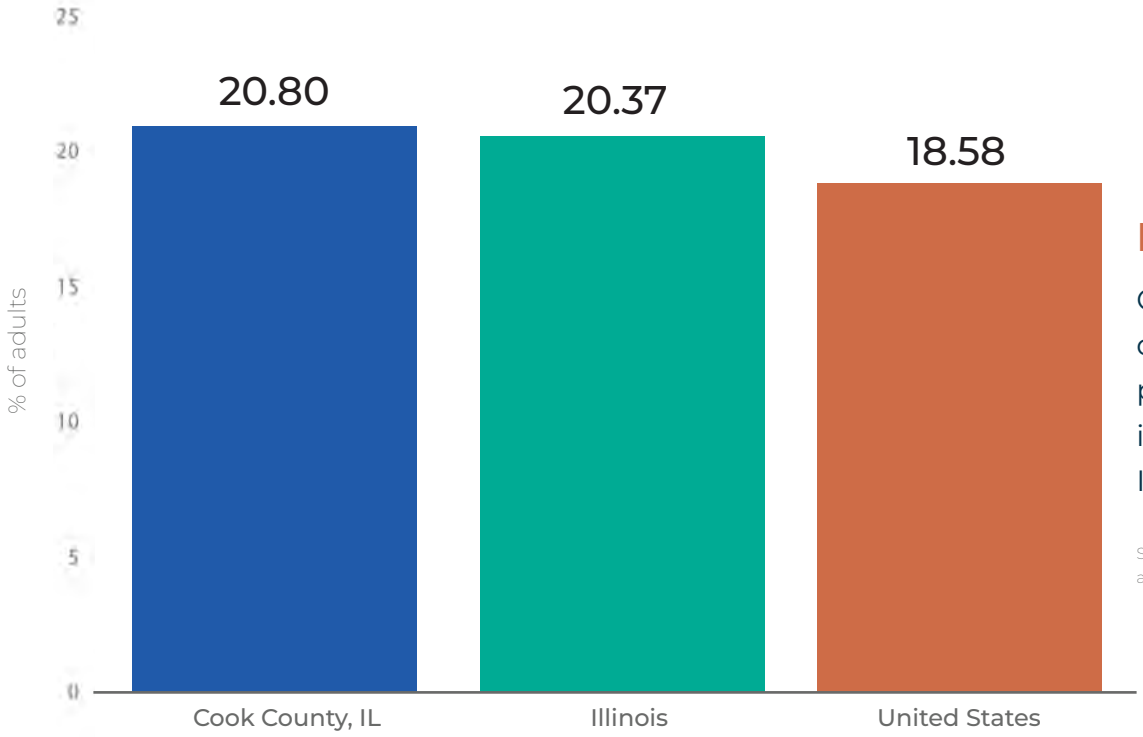


Figure 181.

Chart of binge drinking rate as a percentage of adults in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024q)

In Cook County, there were 60.0 alcohol related emergency department deaths and 17.8 alcohol related hospitalizations per 10,000 population (Figure 182). The rate of emergency department visits was highest among Black individuals at 84.0, 60% higher than among white individuals (Figure 182). White individuals had the highest rate of hospitalizations at 22.3, 50% higher than Black and Hispanic individuals (Figure 182).

Figure 182.

Table of alcohol-related emergency department visit rate and hospitalization rate per 10,000 residents by race and ethnicity, Cook County, Illinois, 2022

	ALCOHOL-RELATED EMERGENCY DEPARTMENT VISIT RATE PER 10,000 RESIDENTS		ALCOHOL-RELATED HOSPITALIZATION RATE PER 10,000 RESIDENTS	
	COOK	IL	COOK	IL
White	45.2	38.3	22.3	16.6
Black	84	89.6	13.7	13.1
Hispanic	59.1	49.5	13.4	11.6
Total	60	47.8	17.8	15.2

Source: (Illinois Department of Public Health, 2022b)

In addition to the human cost, excessive alcohol use cost Illinois taxpayers $9.7 billion in 2010 (about $14 billion in 2024), which translates to more than $750 per person (more than $1,000 in 2024) (National Center for Chronic Disease Prevention and Health Promotion (U.S.). Division of Population Health, 2022).

DRUG USE

Rates for substance use-related emergency department (ED) visits and hospitalizations in Cook County are higher than for Illinois overall. In 2022, Cook County had 44.1 substance use-related ED visits and 8.8 substance use-related hospitalizations per 10,000 population (Figure 183). For both ED visits and hospitalizations, Black communities had significantly higher rates than either white or Hispanic communities (Figure 183). The hospitalization rate for Black individuals was 4 times higher than white individuals and the ED visit rate was almost 7 times higher (Figure 183).

Figure 183.

Table of substance use-related emergency department visit rate and hospitalization rate per 10,000 residents by race and ethnicity, Cook County, Illinois, 2022

	SUBSTANCE USE-RELATED EMERGENCY DEPARTMENT VISIT RATE PER 10,000 RESIDENTS		SUBSTANCE-USE RELATED HOSPITALIZATION VISIT RATE PER 10,000 RESIDENTS	
	Cook County	**IL**	**Cook County**	**IL**
White	18	16.2	5.3	4.3
Black	124.2	96.6	21.9	17.3
Hispanic	28.1	16.7	4.3	3.2
Total	44.1	28.5	8.8	6

Source: (Illinois Department of Public Health, 2022b)

Substance use among youth has been declining since 2020 (Miech et al, 2024). In 2024, among Suburban Cook County twelfth graders, e-cigarette and vape use was 15% (down from 30% in 2020), marijuana use was 21%, (down from 33% in 2020), and tobacco use was 8% (down from 11% in 2020); alcohol use had the smallest decrease, from 53% in 2020 to 43% in 2024 (Figure 184).

Figure 184.

Table of twelfth grade students who reported using substances in the last year as a percentage of surveyed twelfth grade students, Suburban Cook County, Illinois, 2020-2024

	2020	2024	% DECREASE
Alcohol use	53%	43%	18%
Marijuana	33%	21%	36%
E-Cigarettes/vape	30%	15%	50%
Any tobacco	11%	8%	27%
Illicit drugs (except Marijuana	6%	2%	67%
Prescription/OTC	3%	1%	67%

Source: (Illinois Department of Human Services, 2020, 2024a)

Overdoses

Over the past several years, drug-related mortality has been increasing in Chicago and Suburban Cook County. In 2020, during the COVID-19 pandemic, drug overdose deaths hit a historic high in the United States, exceeding 90,000 (Santhanam, 2022). Overdose deaths disproportionately affect Non-Hispanic Black communities, with Non-Hispanic Black individuals making up 53% of deaths compared to 31% for non-Hispanic white individuals (Figure 185).

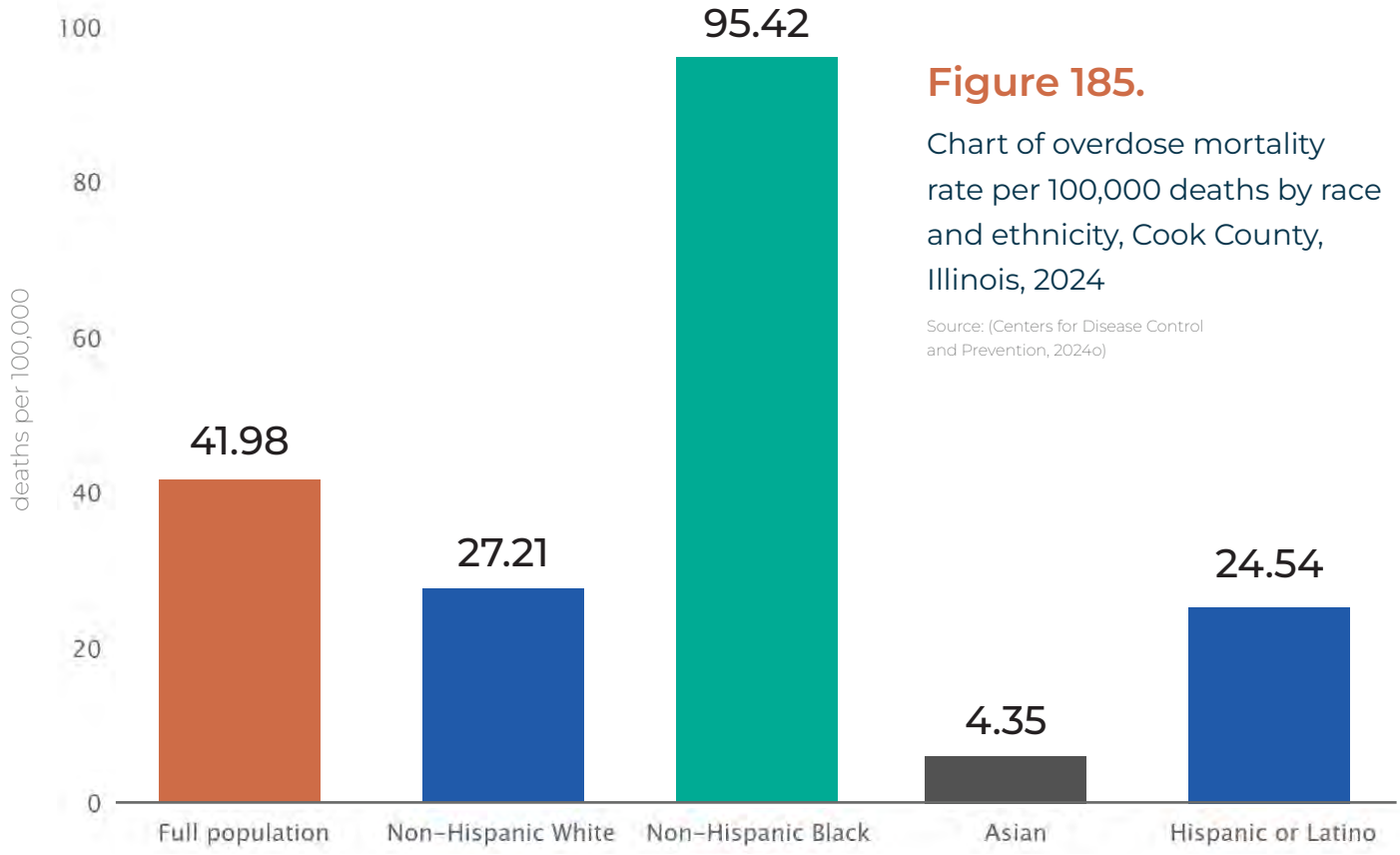


Figure 185.

Chart of overdose mortality rate per 100,000 deaths by race and ethnicity, Cook County, Illinois, 2024

Source: (Centers for Disease Control and Prevention, 2024o)

> "[The disproportionate opioid overdose death rate] is one of the most physical ways in which you can see the impact of racism in our communities."
>
> — Toni Preckwinkle, Cook County Board President

Solutions

When asked about the top three things their community needs to be healthy, survey respondents selected several factors related to mental health. The top response was the "ability to access mental healthcare services in a reasonable amount of time" with 26% of respondents ranking it in their top three (Figure 172).

Figure 186.

Part 1 of 2. Table of community suggested solutions to substance use-related top community health issues

THEME	SUMMARY
Increased healthcare access	Participants emphasized the need for better access to high-quality healthcare services, including mental healthcare, substance abuse programs, preventive services, and specialized care for vulnerable populations like youth, older adults, and people experiencing homelessness. Community services such as housing assistance and emergency food programs were seen as equally important to the health and wellbeing of communities. • Suggestions included increasing the number of healthcare providers, improving accessibility through transportation options, and streamlining processes to reduce wait times. Mobile health clinics and outreach efforts were proposed to reach underserved areas and populations effectively. School-based health services were another common suggestion. • **Enhanced coordination:** Community members also voiced a need for enhanced coordination between institutions, including hospitals, community organizations, and government agencies, to ensure seamless care. • **Tackling stigma and cultural barriers:** Participants identified stigma around mental health and healthcare as a barrier to seeking help. They proposed community-driven campaigns to normalize discussions about mental health and to educate residents about the benefits of seeking care. In addition, respondents advocated for culturally relevant healthcare services that respect the diverse backgrounds of Cook County residents. • **Community based programs:** Strengthening existing community resources, such as food distribution programs, housing programs, and free counseling services, was a recurring theme.
Tackling stigma and cultural barriers	Participants identified stigma around mental health and healthcare as a barrier to seeking help. They proposed community-driven campaigns to normalize discussions about mental health and to educate residents about the benefits of seeking care. In addition, respondents advocated for culturally relevant healthcare services that respect the diverse backgrounds of Cook County residents. • **Tackling stigma and cultural barriers:** Participants identified stigma around mental health and healthcare as a barrier to seeking help. They proposed community-driven campaigns to normalize discussions about mental health and to educate residents about the benefits of seeking care. In addition, respondents advocated for culturally relevant healthcare services that respect the diverse backgrounds of Cook County residents. • **Community based programs:** Strengthening existing community resources, such as food distribution programs, housing programs, and free counseling services, was a recurring theme.
Expansion of youth programs	Youth programs were frequently mentioned as areas needing attention. • **After-school activities:** Implement or expand programs to provide safe, structured environments for youth such as sports clubs and homework help initiatives. • **Mentorship and guidance:** Foster mentorship opportunities for personal and professional growth. Specific examples include Boys and Girls clubs and programs like UI Health CHAMPIONS. • **Workforce development:** Introduce job training and career development initiatives targeting young people.

Figure 186.

Part 2 of 2. Table of community suggested solutions to substance use-related top community health issues

THEME	SUMMARY
Mental health and trauma support	Offer accessible mental health services to address trauma stemming from exposure to violence, fostering healing and resilience within communities.
Enhance access to mental health services	• **Increasing the availability of licensed mental health professionals**: Participants expressed difficulty in accessing licensed therapists and called for hospitals to hire more professionals to address gaps in mental health services. • **Providing holistic care for priority populations**: Suggestions included integrating mental health services with care for the homeless and those struggling with substance abuse. • **Community based care**: Invest in mental health infrastructure, including outpatient clinics, telehealth services, and crisis intervention programs. • **Crisis care:** Enhance emergency care and crisis intervention services for mental health and substance abuse issues.
Address social determinants of health	Hospitals were encouraged to invest in programs addressing housing instability, food insecurity, and economic opportunities as part of a comprehensive approach to health.

> "I grew up in Section 8 housing. So, they had a lot of opportunities for us to go do hearing tests and vision tests. And it seemed like our health was very important to the building because they would host these events right in front. But then the problem was that we had an increased gang population in our building. And so, they had to stop hosting these events. And then I feel like less and less people were getting the healthcare that they needed because it was so accessible. It was always like we have a mobile clinic coming to our building and that's how you could get your hearing test, your vision test done for school."
>
> — NAMI Metro Suburban focus group participant

> “So, I’m in West Garfield. There are a lot of organizations in and around West Garfield that do various things, but they’re not interconnected. And if they were interconnected, I think that it would make a difference to both the seniors and the youth.”
>
> — NAMI Metro Suburban focus group participant

MORTALITY AND LEADING CAUSES OF DEATH

Age-adjusted mortality rates reveal a higher mortality rate in Cook County compared to rates in United States and Illinois (Figure 187).

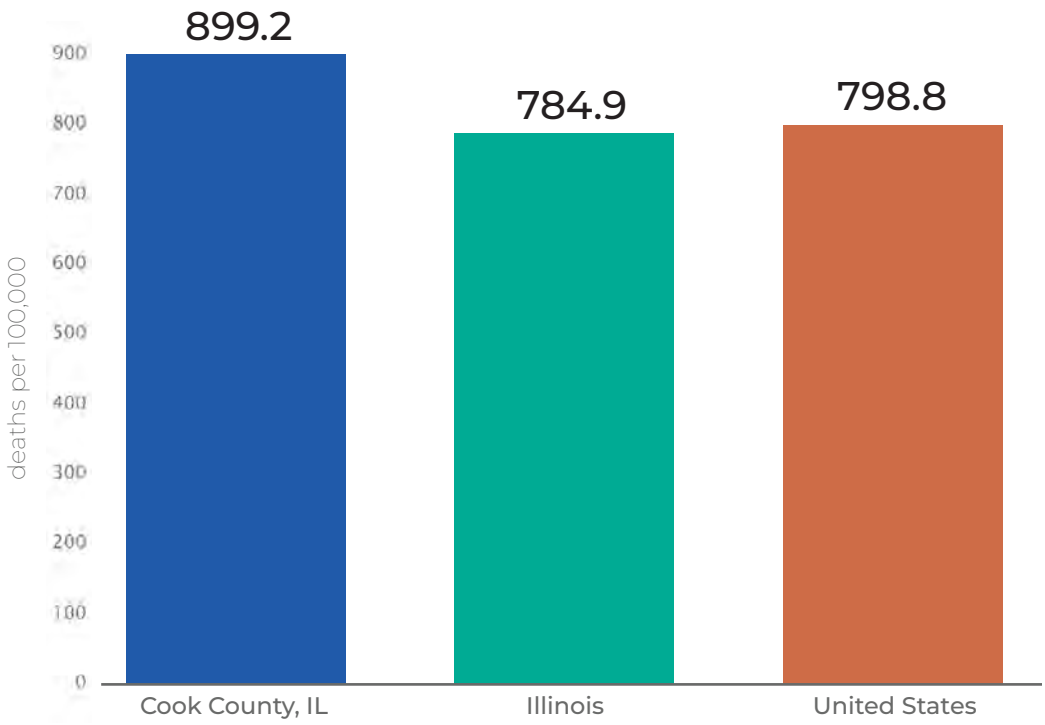


Figure 187.

Chart of all-cause mortality rate per 100,000 population for Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024o)

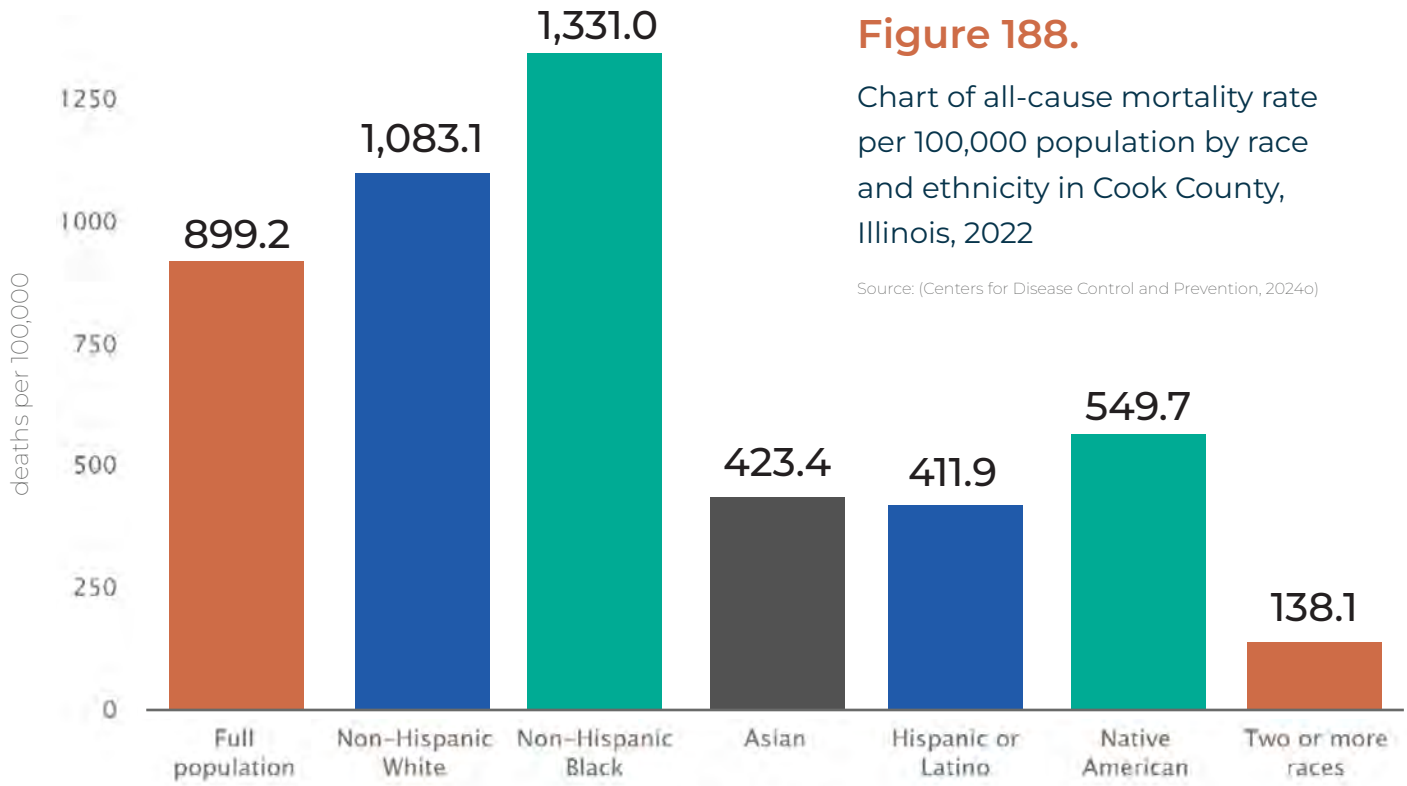


Figure 188.

Chart of all-cause mortality rate per 100,000 population by race and ethnicity in Cook County, Illinois, 2022

Source: (Centers for Disease Control and Prevention, 2024o)

Of the top ten leadings causes of death, researchers say half are preventable and related to chronic disease burden (Centers for Disease Control and Prevention, 2024l) (Figure 189). As previously mentioned, inequities in the burden of chronic-disease-related mortality within communities are largely driven by the social determinants of health such access to healthy foods, access to safe exercise spaces, household income, access to quality education, housing stability, access to quality healthcare, community safety, and exposure to trauma. The occurrence of chronic disease or disability is 3.7 times higher among adults with an income less than $25,000 and was 2.6 times higher in adults who are not high school graduates (United Health Foundation, 2023).

Figure 189.

Table of leading causes of death in the United States, 2022

LEADING CAUSE OF DEATH	NUMBER OF
Heart disease	702,880
Cancer	608,371
Accidents (unintentional injuries)	227,039
COVID-19	186,552
Stroke (cerebrovascular diseases)	165,393
Chronic lower respiratory diseases	147,382
Alzheimer's disease	120,122
Diabetes	101,209
Nephritis, nephrotic syndrome, and nephrosis	57,937
Chronic liver disease and cirrhosis	54,803

Source: (Centers for Disease Control and Prevention, 2024l)

COVID-19 mortality

In 2023, the COVID-19 fatality rate, or the percentage of COVID-19 cases that resulted in death, was 1.0% for Cook County and Illinois, and 1.1% for the United States (Centers for Disease Control and Prevention, 2024o). COVID-19 accounted for 11.9% of deaths in Illinois and 13.7% in the United States that year (Illinois Department of Public Health, 2024b).

Figure 190.

Table of COVID-19 deaths by race and ethnicity in Chicago, Illinois, 2020-2025

	COOK COUNTY	CHICAGO
Cumulative total of COVID related deaths as of Jan. 2025	15,493	7,455
Black cumulative total	4,714	3,097
White cumulative total	6,775	2,035
Latino cumulative total	2,780	1,762
Total COVID deaths in 2024	27	11

Source: (Cook County Medical Examiner's Office, 2025a)

Non-Hispanic Blacks have the highest relative burden of COVID-19 mortality in Chicago and nationwide (Bassett et al., 2020; Mackey et al., 2021). Preliminary research has indicated that socioeconomic factors such as educational attainment, housing, occupation, and prior health status are strongly contributing to continued racial and ethnic COVID-19 mortality inequities (Feldman & Bassett, 2021b).

CONCLUSIONS AND NEXT STEPS

CHALLENGES AND GAPS

One of the main challenges of the CHNA is the inconsistent availability of data. For secondary data, statistics on youth, LGBTQIA+ populations, unhoused populations, and those with limited English proficiency is limited. In Suburban Cook County, any data collected or reported by municipality is inconsistently available across jurisdictions including hospitalization, community safety, and mortality data.

Collecting community input data also had challenges. Community members, particularly in priority populations, are facing survey fatigue. So much qualitative data collection has been done in the past few years, often with no follow-up, that communities are reluctant to donate their time and information. Recruitment for focus groups also faced challenges. Focus group participants were mostly recruited by partner organizations, but for the few focus groups that were recruited more broadly, interference from scammers and spam made finding legitimate participants difficult.

COMMUNITY IDENTIFIED POPULATIONS

Community input shaped the identification of key health priorities across Cook County, reflecting a shared urgency around the root causes of health inequities. Residents and community-based organizations consistently emphasized the need for improved access to mental health care, support for managing chronic conditions, and expanded resources to address substance use. Housing instability, youth needs, food insecurity, and community safety also emerged as pressing concerns, each deeply intertwined with social and economic inequities. These priorities were identified through nearly 1,800 survey responses and extensive focus group participation. They highlight the importance of investing in culturally responsive services, youth programming, community-based supports, and structural change to improve health and advance equity across the region.

NEXT STEPS

After completing the CHNA, hospitals develop implementation plans around their chosen priorities. The Alliance for Health Equity (AHE) will work with member partners to support implementation.

Plan for continued community engagement

The AHE and partner hospitals engage community members and organizations throughout the process of implementation. Community organizations participate in all AHE workgroups, most hospital partners have community boards or councils who they meet with regularly, and general community engagement is occasionally done to establish priorities, review potential programs, or other forms of ground truthing.

How the CHNA data will be used to drive implementation

CHNA community input data and secondary data are used to determine the priority areas and populations to be centered in implementation planning. For example, mental health issues were identified as a top concern through the community input survey and focus groups. The secondary data also shows a large unmet need for mental healthcare. Because of this, mental health will be a major priority for implementation planning. The needs and suggestions from communities around addressing mental health issues will be used to develop new programs and expand current programs to address the needs of communities.

ACKNOWLEDGEMENTS

The Alliance for Health Equity extends deep gratitude to the many individuals and organizations who made the 2025 Community Health Needs Assessment possible. This collaborative effort was led by the Illinois Public Health Institute in partnership with Alliance member hospitals, health departments, community-based organizations, and regional stakeholders across Chicago and Suburban Cook County.

We are especially grateful to the nearly 1,800 residents who completed surveys, and the many community members who shared their experiences and insights in focus groups. Your voices were critical in identifying the health issues that matter most and shaping strategies for change. We also thank the community-based partners who facilitated data collection and ensured that input from historically marginalized populations was centered throughout this process.

This CHNA reflects the strength and commitment of our partners to advance health and racial equity. We thank you for your leadership, collaboration, and ongoing work to improve the health and well-being of all Cook County residents.

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FIGURES

APPENDIX

AHE MEMBER HOSPITALS

- Advocate Children's Hospital
- Advocate Christ Medical Center
- Advocate Illinois Masonic Medical Center
- Advocate Lutheran General Hospital
- Advocate South Suburban Hosptial
- Advocate Trinity Hospital
- Gottlieb Memorial Hospital
- Holy Cross Hospital
- Insight Hospital and Medical Center
- Jackson Park Hospital and Medical Center
- Loretto Hospital
- Loyola University Medical Center
- Lurie Children's Hospital
- MacNeal Hospital
- Mount Sinai Hospital
- Northwestern Medicine Palos Hospital
- Northwestern Memorial Hospital
- Rush Oak Park Hospital
- Rush University Medical Center
- Schwab Rehabilitation Hospital
- South Shore Hospital
- University of Illinois Hospital

CHNA STEERING COMMITTEE MEMBERS

CONTACT	TITLE	ORGANIZATION
Lawanda Holmes-Williams	Director, Community Health - Southland	Advocate Health
Elvis Muñoz	Director, Community Health, Central Illinois	Advocate Health
Rukiyat Lawal	Community Health Program Manager	Advocate Health
Jackie Rouse	Area Vice President, Commuinty Health - Midwest	Advocate Health
Kelli Day	Director of Operations, Pat Magoon Institute	Ann & Robert H. Lurie Children's Hospital of Chicago
Zaina Awad	Communications Manager, Communications	Ann & Robert H. Lurie Children's Hospital of Chicago
Mervin Dino	Assistant Commissioner, Bureau of Inclusion, Diversity, Equity & Access	Chicago Department of Public Health
Deloris Walker	Regional Health Officer	Cook County Department of Public Health
Dillon Bannis, MD	Chief Medical Officer	Insight Hospital and Medical Center
Rebecca McCauley	Assistant VP	Jackson Park Hospital
Margo Brooks-Pugh	Foundation President & VP of Marketing	Jackson Park Hospital
Kenneth McGhee	Chief Financial Officer	Loretto Hospital
Michelle Peters	Regional Vice President, Community Health & Well-Being	Loyola Medicine, Trinity Health
Erica Sun	Senior Coordinator, Community Health & Well-Being	Loyola Medicine, Trinity Health
Holly Trandel-Manprisio	Program Director, Community Services	Northwestern Medicine
Tyler Fisher	Program Manager	Northwestern Medicine
Julia Bassett	System Manager of Health and Community Benefits	Rush University System for Health
Traci Simmons	Director, Community Health and Engagement	Rush University System for Health
Melissa Gutierrez Kapheim	Director Health Equity and Assessment Research	Sinai Urban Health Institute, Sinai Health System
Helen Margellos-Anast	President, Sinai Urban Health Institute	Sinai Urban Health Institute, Sinai Health System
Leslie Rogers	CEO	South Shore Hospital
Jenise Celestin	Director of Community Relations	Swedish Hospital, Endeavor Health
Cotis Mitchell	Director of Health Equity	University of Illinois Hospital & Health Sciences System
Aisha Achesah	Assistant Director, Health Equity Programs	University of Illinois Hospital & Health Sciences System

2024 COMMUNITY INPUT SURVEY TOOL

Community Input Survey

for Chicago and Suburban Cook County

ALLIANCE for HEALTH EQUITY | Hospitals and Communities Improving Health Across Chicago and Cook County

The Alliance for Health Equity is a group of over 30 hospitals, local health departments, and community organizations in Chicago and Suburban Cook County that are working together to conduct a Community Health Needs Assessment. Your input is very important and will help create a plan to improve community health. The survey should take about 7-10 minutes to complete. Your responses are anonymous, and you will not be asked your name. If you have any questions about the survey, please contact **AHE@iphionline.org**. More information about the process is available online at **www.allhealthequity.org**.

This survey is intended for people of all ages who live in Chicago or Cook County suburbs.
If you **do not live in Chicago or Cook County**, please return the survey to the survey distributor.

Tell us about your community

Community can have many different meanings. For this survey, we are interested in learning about the places where you live, work, and play. The information you share is anonymous.

1. **What is your home zip code? (5 digits)**

2. **How many years have you lived in your community?**

3. **What are the best things about your community?**

4. **How would you rate the overall health of your community?**

Very Unhealthy	Unhealthy	Somewhat Healthy	Healthy	Very Healthy
○	○	○	○	○

5. **How would you rate your personal health?**

Very Unhealthy	Unhealthy	Somewhat Healthy	Healthy	Very Healthy
○	○	○	○	○

1

6. What are the biggest health issues in your community? *(Choose three)*

- ○ ADHD (Attention Deficit Hyperactivity Disorder)
- ○ Adult mental health (depression, anxiety, PTSD, suicide, etc.)
- ○ Autism Spectrum Disorder
- ○ Child and adolescent mental health (depression, anxiety, PTSD, suicide, etc.)
- ○ Substance-use (alcohol, prescription misuse, and other drugs)

- ○ Age-related physical illnesses (arthritis, hearing loss, vision loss)
- ○ Cancers (breast, prostate, skin, colon, etc.)
- ○ Chronic pain
- ○ Cognitive conditions (Alzheimer's, dementia, Parkinson's)
- ○ Diabetes (high blood sugar)
- ○ Heart disease and stroke
- ○ Lung disease (asthma, COPD)

- ○ Dental problems
- ○ Infant health (preterm birth, infant mortality)
- ○ Maternal health (prenatal care, gestational diabetes, pre-eclampsia)
- ○ Obesity (obese, overweight)

- ○ Child abuse (physical or emotional, neglect, sexual assault)
- ○ Domestic violence (intimate partner/relationship, physical or emotional, sexual assault)
- ○ Police brutality
- ○ Property crime (theft, burglary, vandalism)
- ○ Violent crime (gun violence, murder, assault)

- ○ Motor vehicle crash injuries
- ○ Preventable injuries (falls, drowning, concussions)

- ○ Homelessness and housing instability
- ○ Hunger
- ○ Racism and other discrimination

- ○ COVID-19 pandemic
- ○ Illnesses that can be prevented by vaccines (measles, chicken pox, HPV, etc.)
- ○ Infectious diseases (hepatitis, TB, flu, etc.)
- ○ Sexually Transmitted Infections (STIs/STDs, HIV)

7. What does your community need to be healthy? *(Choose three)*

- ○ Activities for teens and youth
- ○ Housing resources (housing services, emergency shelters, transitional housing)
- ○ Resources for food (pantries, food banks, love kitchens, SNAP programs)
- ○ Workforce training and employment opportunities
- ○ Income diversity

- ○ Affordable quality childcare and schooling
- ○ Arts and cultural events
- ○ Safe and affordable housing
- ○ Safety and low crime
- ○ Spaces for religion and spirituality
- ○ Strong family life
- ○ Welcoming neighbors and connections to community

- ○ Ability to access mental health care services within a reasonable amount of time
- ○ Ability to access physical health care services within a reasonable amount of time
- ○ Access to quality pediatric care
- ○ Access to quality prenatal care
- ○ Racial and ethnic diversity in healthcare providers
- ○ LGBTQIA+ friendly healthcare services

- ○ Clean air
- ○ Easy access to public transportation (buses, trains)
- ○ Parks and recreational spaces
- ○ Safe water
- ○ Walkable neighborhoods

8. Please rate your agreement with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I am satisfied with the quality of life in my community	○	○	○	○	○
I am satisfied with the healthcare system in my community	○	○	○	○	○
I am satisfied with the availability of affordable housing in my community	○	○	○	○	○
I am satisfied with the availability of fresh and healthy foods in my community	○	○	○	○	○
I am satisfied with the availability of affordable childcare in my community	○	○	○	○	○
I am satisfied with the number of arts and cultural events in my community	○	○	○	○	○
My community is a good place to raise children	○	○	○	○	○
My community is a good place to retire	○	○	○	○	○
My community has good schools	○	○	○	○	○
There is economic opportunity in my community	○	○	○	○	○
My community has clean air and water	○	○	○	○	○
My community is a safe place to live	○	○	○	○	○
There are networks of support for individuals and families during times of stress and need in my community	○	○	○	○	○
All individuals and groups can contribute to and participate in the community	○	○	○	○	○
There is an active sense of civic responsibility, civic engagement, and civic pride in shared accomplishments in my community	○	○	○	○	○

Tell us about yourself

This section will help us learn more about the diverse groups of people living in Chicago and Suburban Cook County and their specific health needs. The information you share is anonymous.

9. In the past 12 months, have you delayed any medical care such as annual physicals because of the COVID-19 pandemic?

◯ Yes ◯ No

10. In the past 12 months, have you received a flu vaccine?

◯ Yes ◯ No

11. If you answered NO to question 10, why not?

- ○ Wait time for appointment
- ○ Cost of service
- ○ Transportation
- ○ Inconvenient hours
- ○ Lack of provider
- ○ No insurance
- ○ I am not at risk
- ○ Did not want to get vaccinated
- ○ Other (write in)
- ○ Prefer not to respond

12. In the past 12 months, have you received a COVID-19 vaccine or booster?

◯ Yes ◯ No

13. If you answered NO to question 12, why not?

- ○ Wait time for appointment
- ○ Cost of service
- ○ Transportation
- ○ Inconvenient hours
- ○ Lack of provider
- ○ No insurance
- ○ I am not at risk
- ○ Did not want to get vaccinated
- ○ Other (write in)
- ○ Prefer not to respond

14. What is your age?

- ○ Younger than 10
- ○ 10-13
- ○ 14-17
- ○ 18-24
- ○ 25-34
- ○ 35-44
- ○ 45-54
- ○ 55-64
- ○ 65-74
- ○ 75-84
- ○ 85 and older
- ○ Prefer not to answer

15. What is your gender identity?

- ○ Female
- ○ Male
- ○ Transgender female
- ○ Transgender male
- ○ Non-binary
- ○ Another gender identity (write in)
- ○ Prefer not to answer

16. What is your sexual orientation?

- ○ Heterosexual, straight
- ○ Gay or lesbian
- ○ Bisexual
- ○ Asexual
- ○ Another sexual orientation (write in)
- ○ Prefer not to answer

17. What is your racial and ethnic identity? (choose all that apply)

- ○ African American/Black
- ○ American Indian or Alaskan Native
- ○ Hispanic/Latino(a)
- ○ Middle Eastern/Arab American or Persian
- ○ Asian, Pacific Islander, or Hawaiian Native
- ○ White
- ○ Another race or ethnicity (write in)
- ○ Prefer not to answer

18. What is the highest level of education you have completed?

- ○ Elementary school (K-5)
- ○ Middle school (6-8)
- ○ Some high school
- ○ High school graduate or GED
- ○ Vocational or technical school
- ○ Some college
- ○ College graduate or higher
- ○ Prefer not to answer

19. Including yourself, how many people live in your home?

20. How many children or youth are living in your home?

	0	1	2	3	4	5 or more
Number of children aged 0-4 in my home	○	○	○	○	○	○
Number of children aged 5-12 in my home	○	○	○	○	○	○
Number of adolescents aged 13-17 in my home	○	○	○	○	○	○
Number of young adults aged 18-24 in my home	○	○	○	○	○	○

21. **Does anyone in your household live with a physical, mental, or intellectual disability?**

◯ Yes ◯ No ◯ Prefer not to answer

22. **Do you require caregiver support due to age, disability, or any other reason?**

◯ Yes ◯ No ◯ Prefer not to answer

23. **What is your annual household income?**

- ○ Less than $10,000
- ○ $10,000 to $19,999
- ○ $20,000 to $39,999
- ○ $40,000 to $59,999
- ○ $60,000 to $79,999
- ○ $80,000 to $99,999
- ○ $100,000 to $199,999
- ○ Over $200,000
- ○ Prefer not to answer

24. **Does anyone in your household have a checking or savings account?**

◯ Yes ◯ No ◯ Prefer not to answer

25. **What is your employment status? (Choose all that apply)**

- ○ Employed full-time
- ○ Employed part-time
- ○ Retired
- ○ Student
- ○ Self-employed
- ○ Not employed
- ○ Prefer not to answer

26. **Do you have stable housing or shelter?**

◯ Yes ◯ No ◯ Prefer not to answer

27. **If you answered YES to question 26, do you rent or own your home?**

◯ Rent ◯ Own ◯ Other ◯ Prefer not to answer

28. **If you answered NO to question 26, where did you sleep last night?**

- ○ With a friend or family member
- ○ In a motel or hotel
- ○ Car or motor vehicle
- ○ Shelter
- ○ Spent the night unhoused
- ○ Prefer not to answer

29. **Do you have reliable internet access at home?**

◯ Yes ◯ No ◯ Prefer not to answer

Thank you for taking our survey! Your response is very important to us. If you have any questions about the survey, please contact **AHE@iphionline.org**. Survey results will be posted on **allhealthequity.org**.

FOCUS GROUP QUESTIONS – 2025 ALLIANCE FOR HEALTH EQUITY CHNA

Structure

- 90 minutes
- Survey completion as participants arrive and are seated

TEAM INTROS/CONSENT

Explanation of purpose and process

Purpose:

The Alliance for Health Equity is a partnership of over 30 hospitals, six local health departments, and nearly 100 community-based organizations. We are gathering information about how hospitals, health departments, community organizations, and community residents can work together to improve health in communities across Chicago and Suburban Cook County. Our discussion will be focused on your thoughts about what makes a healthy community and your input about strategies that could be used to improve **health** in your community and other communities in Chicago and Suburban Cook County.

Process:

There are no wrong answers. We are going to talk about your experiences, observations and perceptions. You won't hurt our feelings or make us feel good with whatever opinions you might share. We are interested in hearing your point of view even if it is different from what others have expressed. So, please feel free to speak open and honestly.

When we speak about community it can have different meanings. For example, it can mean your family, the people you live or work with, the neighborhood you live in, a group of people you belong to. We are interested in hearing about your community, no matter how you define it.

[Notetaker Name] will be a note taker for the discussion today. An overall summary of the information shared by the different discussion groups will be written and shared online. There will not be any names attached to the comments and ideas in the notes or in the final report. We would like to record today's discussion to ensure that we completely capture your input. Is everyone ok with us recording the discussion?

You will be able to access the final report in **Spring 2025**.

Are there any questions before we start?

Introduction

1. Introduction activity (first names and pronouns on tent cards for in-person events)

2. What communities are you representing today?

Community Perceptions

3. Today we are going to be talking a lot about the community you represent. How would you describe your community?
    a. If someone were to join your community, what would you say are the best things about it?

4. The Alliance for Health Equity is working on strategies for improving the health of communities in Cook County. Some of the key areas we are working in include:
    - Reducing health problems caused by social, structural, and economic inequities
    - Improving mental health and reducing substance use disorders
    - Improving prevention and management of chronic conditions
    - Reducing maternal and child health inequities
    - Improving adolescent and child health
    - Improving access to quality health care
        a. How have these issues affected your community?
        b. Thinking about day-to-day life – working, getting kids to school, taking care of yourself – things like that: What are some of the struggles that you or someone in your community has to deal with on a day-to-day basis?
        c. What populations or groups of people do you think struggle the most with challenges in your community?
        d. Does the COVID-19 Pandemic continue to impact your community? If so, how?
        e. Please share any important health issues that we haven't talked about yet.

5. Based on what we have talked about so far, what do you think are the most urgent health concerns in your community? [Possible Round Robin Activity]

6. Thinking about health and wellness in general, what keeps you healthy?/What do you do to be healthy?
    a. What makes it easier to be healthy in your community?

Solutions

7. [Select top issues discussed] Let's talk about a few of the issues you mentioned.
    a. What programs, services, or policies are you aware of that currently focus on these issues?
    b. What programs, services, or policies are currently NOT available and you think they should be?
    c. What should hospitals and health departments do to address these issues?
    d. If hospitals had the chance to invest in community development, what do you think they should focus on first?
    e. What could hospitals be doing differently?
    f. What is the role of communities in these solutions?

Visioning

8. When you think about your community three years from now, what would you like to see? What is your vision for the future?
    a. What needs to happen to make this vision a reality?

ALLIANCE for HEALTH EQUITY

Illinois Public Health Institute
Center for Community Capacity Development

310 S Peoria Street, Suite 404
Chicago, IL 60607

(312) 850-4744

www.allhealthequity.org

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